

# WOMANKIND HEALTH HISTORY

Patient name: \_\_\_\_\_ Age: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Reason for today's visit: \_\_\_\_\_

Please check all that apply	You	Family	Practitioner Comments
Stroke, High blood pressure			
Heart disease, rheumatic fever			
Diabetes			
Cancer			
Breast cancer			
Blood disorder			
Lung disease, TB, asthma			
Migraines, seizures			
Mental or emotional disorder			
Kidney, bladder problems			
Liver, gallbladder problems			
Skin problems, disease			
Stomach, bowel problems			
Bone, muscle disease			
Thyroid or metabolic disorders			
Blood clots, varicose veins			
Pelvic infection, disease			
Sexually transmitted disease			
HIV/AIDS			
DES Daughter			
Fertility problems			
Abnormal pap smears		NA	
Surgery, hospitalizations		NA	
Blood transfusion		NA	
Other			

**ALLERGIES:**

DRUG: \_\_\_\_\_ FOOD: \_\_\_\_\_ OTHER: \_\_\_\_\_

Daily medications, supplements, herbals: \_\_\_\_\_

Last PAP smear \_\_\_\_\_ Where? \_\_\_\_\_ Was it normal? \_\_\_\_\_  
 Date last menstrual period started? \_\_\_\_\_ Menses every \_\_\_\_\_ days x \_\_\_\_\_ days duration.  
 I stopped having periods \_\_\_\_\_. On hormone replacement currently? \_\_\_\_\_ Previously? \_\_\_\_\_  
 Number of pregnancies? \_\_\_\_\_ Number of miscarriages or abortions? \_\_\_\_\_ Number of living children? \_\_\_\_\_  
 Birth control method? \_\_\_\_\_ Pregnancy desired? \_\_\_\_\_  
 Age at first intercourse? \_\_\_\_\_ # partners past year \_\_\_\_\_ past 5 years \_\_\_\_\_  
 When you have sex, is it with men, women or both (circle one) How long with current partner? \_\_\_\_\_  
 Do you use condoms: always, sometimes, never (circle one)  
 To the best of your knowledge have any of your sex partners been: injecting drug user, bisexual, HIV/AIDS  
 positive, or had more than 5 sex partners besides you? (circle any that apply)  
 Have you ever had sex to get drugs/money or a place to live? \_\_\_\_\_ Use injected drugs? \_\_\_\_\_  
 Have you been forced to have sex against your will? Sexually assaulted or abused? \_\_\_\_\_  
 Has a partner ever physically hurt, pushed or shoved you? \_\_\_\_\_  
 Do you have pain or bleeding with sex? \_\_\_\_\_ Other problems? \_\_\_\_\_  
 Is your sex life satisfactory? \_\_\_\_\_  
 Do you smoke? \_\_\_\_\_ How much per day? \_\_\_\_\_ Alcohol use? \_\_\_\_\_ Drug use? \_\_\_\_\_  
 Recent weight change? \_\_\_\_\_ Exercise type and frequency? \_\_\_\_\_  
 Last mammogram \_\_\_\_\_ Hemocult \_\_\_\_\_ Colonoscopy \_\_\_\_\_ Cholesterol test \_\_\_\_\_  
 Are all immunizations up to date? \_\_\_\_\_ Rubella status \_\_\_\_\_

**Nurse Practitioner Signature**