



PATIENT HISTORY FOR FEMALE HEALTH MAINTENANCE EXAM

Name: _____ Birthdate: ____/____/____ Today's date: ____/____/____

Please list all Prescription Medications/Over-the-counter/Vitamins/Supplements you are currently taking:

Table with 5 columns: Medication Name, Strength, Frequency, Reason for medication, Refill needed? (Y/N)

List any Medication Allergies you may have:

Medication: _____ Reaction: _____

SOCIAL HISTORY

Occupation: _____ Occupational hazards? _____
Marital Status: [] Married [] Single [] Divorced [] Widowed [] Life Partner [] Other: _____
Who lives in your home? [] Live Alone [] Spouse [] Children: _____ [] Father [] Mother [] Other: _____
Do you use Tobacco? [] Never [] Current user [] Former user Type: [] Cigarettes [] Chew [] Pipe [] Other: _____
Units/day: [] .5 [] 1 [] 1.5 [] 2 [] Other: _____ Years used: _____ Years quit: _____
Do you drink Alcohol? [] No [] Yes [] Formerly How many drinks per week? [] 1-3 [] 4-6 [] 7-10 [] Other: _____
Do you drink Caffeine? [] No [] Yes Type of Caffeine: [] Soda [] Coffee [] Energy drinks [] Other: _____ Amount/day: _____

LIFESTYLE

Activity Level: [] Sedentary [] Moderate [] Vigorous Type of exercise: _____
Exercise Frequency: [] 2-3 times/week [] 3-4 times/week [] Daily [] Never [] Occasionally Hours/week: [] 0-5 [] 5-10 [] 10-15
Do you have a religious affiliation [] Y [] N Religion: _____ Is religion/spirituality an important part of your life? [] Y [] N
Do you practice your religion? [] Y [] N Do you agree to transfusion? [] Y [] N

HOME ENVIRONMENT/SAFETY

Do you have smoke detectors in your home? [] Y [] N Pool/ spa at home? [] Y [] N
Do you have carbon monoxide detectors in your home? [] Y [] N Type of home heating? [] Gas [] Coal [] Electric [] Solar
Falls in the last year? [] Y [] N Number of falls: _____ Radon in the home? [] Y [] N
Firearms at home? [] Y [] N Number of firearms? _____ Locked storage? [] Y [] N
Do you use a seatbelt in the car? [] Always [] Never [] Occasionally

HEALTH MAINTENANCE

Date of last checkup: ____/____/____ Please check one of the following: [] Premenopausal [] Perimenopausal [] Postmenopausal
Date of last menstrual period: ____/____/____ Hysterectomy? [] Y [] N Year: _____
How many times have you been pregnant? _____ Number of live births? _____ Age at first birth? _____
Have you ever had a sexually transmitted disease? [] Y [] N If so, which one? _____
What are you doing to prevent getting HIV or a sexually transmitted disease? _____
Date of last Pap smear: ____/____/____ Have you ever had an abnormal pap? [] Y [] N Date of last Mammogram: ____/____/____
Have you ever had a Colonoscopy? [] Y [] N Date: _____ How many glasses of milk do you drink a day? [] 1 [] 2 [] 3 [] 5 [] 6+
Enter the most recent dates of the following immunizations:
Tetanus _____ Pneumonia _____ Flu _____ Hepatitis B _____ Hepatitis A _____ MMR _____