FAMILY DOCTORS OF VICKSBURG PC

13320 NORTH BOULEVARD ST. VICKSBURG MI 49097 269-649-2012 FAX: 269-649-3752

HISTORY FORM- FEMALE UNDER 65 **Fill out both sides**

Name: ______________________ **DOB:** ______________ **Date:** ___________

How many times have you been pregnant?			
How many children have you had?			
How many miscarriages have you had?			
How many abortions?			
Do you have a problem with a vaginal discharge?			
When was your last pap smear?			
Have you ever had an abnormal pap smear?		If yes, when?	How many?
Age at onset of sexual activity? Circle one	<16	16 or older	
Number of sexual partners?	Last year:	Lifetime:	

Have you ever had a sexually transmitted disease? (gonorrhea, venereal warts, herpes or infection in your fallopian tubes)	
Do you have pelvic pain?	
Do you have pain with intercourse?	
Do you do self breast exams?	
Have you noticed any lumps in your breasts?	
Do you have pain or burning with urination?	
Do you have to urinate frequently?	
Do you have to wear pads because of problems with leaking urine?	
Do you leak urine when you cough or sneeze?	

Have you ever had: (please circle all that apply) Phlebitis Hepatitis Migraine Headaches High Blood Pressure

Section 2: If you are having periods, please answer the following questions. If NOT please skip to section 3

What was the first day of your last menstrual period?	
How often do you have periods?	
How many days do you bleed?	
Do you bleed between periods?	
Do you pass clots with your period?	
Do you bleed after intercourse?	
Do you have cramps or pain before or during your periods?	

What is your current method of birth control? (please circle all that apply)

Tubal ligation Vasectomy Birth control pills Condoms IUD Other ____________________

Section 3: If you have stopped having periods please answer the following questions

How old were you when you stopped having periods? _______ Have you ever been on estrogen or hormone replacements? __________ If yes, when and for how long? ______________________________

Section 4: Do you have a grandparent, parent, sibling or child with a history of the following?

	Who?		Who?
Uterine Cancer		Glaucoma	
Ovarian Cancer		Osteoporosis/hip fracture	
Breast Cancer		Alcoholism	
Colon Cancer		Depression	
Skin Cancer		Aneurysm	
Heart attack/stent/bypass			

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1. Have you ever used tobacco? Yes / No
   If YES: Average packs per day ________
   Number of years you smoked ________
   The year you quit ________
   When are you planning to quit?
   Now / 6 months / Sometime / Never

Prevention:
Which of the following are included in your diet?

	Grains	Veggies	Dairy	Meats	Sweets
A lot					
Some					
Few					

2. Do you drink alcohol? Yes / No
   If YES

	Y	N
Have you ever felt you should cut down?		
Have people ever annoyed you by nagging about your drinking?		
Have you ever felt guilt about your drinking?		
Have you ever had a drink first thing in the morning?		
Has drinking ever affected your job performance?		
Have you ever drank and driven a vehicle?		

Have there been any of these changes in your family? Birth ____ Marriage/Divorce _____ Death _____ Job change ____
Do you exercise? Yes ____ No ____ Activity ________________________________ Number of days per week ________
Time/duration _______________________ minutes/hours ______________________ Exertion: Stroll / Mild / Heavy
Do you always wear seat belts? Yes / No Does your house have a working smoke detector? Yes / No
Do you have firearms at home? Yes / No
If over 30 years old, has your cholesterol level checked in the past 10 years? Yes / No
How many sexual partners have you had in the last: 12 months ________ Lifetime ___________
When was your last dental check-up? _________________
Do you take over the counter weight loss or body building substances? Yes ______ No ________
Do you now have?

Y	N	Unsure	CONST	Y	N	Unsure	GI
			Weight change				Use antacids frequently
			Loss of appetite				Does food get stuck when you swallow
			Problem sleeping				Black or bloody stools
			DERM				Constipation
			Changing mole				Abdominal pain
			Sore that won't heal				Recurrent diarrhea
			Rash				ENDO
			EYES				Do you feel hotter or colder than others?
			Double vision				MUSCULOSKELETAL
			Eye pain				Pain in legs when walking
			ENT				Joint pain
			Hearing loss				ALLERGY
			Balance problems				High fever
			Recurrent sinus/nasal congestion				Severe reaction to bee stings
			Swelling in the neck				Severe reaction to food
			CARDIOVASCULAR	What time of the year do these appear?			
			Wake up at night short of breath				NEUROLOGY
			Legs swell at end of day				New headache
			Chest discomfort when you walk				Frequent headache
			Heart pounds or skips a beat				Stroke that came and went away
			Have you fainted/passed out				PSYCH
			RESPIRATORY				Panicky feeling
			Chronic cough				Trouble remembering things
			Cough up blood				Feel depressed
			Shortness of breath at rest				Wake up frequently at night