TriHealth
Women's Services
Reproductive Endocrinology

Personal Health History

Patient Name: ______________________ Birth Date: __________ Age: _____ Visit Date: ______________

Reason for Visit: ____

Current Health Concerns: ____

Reproductive History:

Menstrual History:

Last menstrual period: ______________ Age at onset: ___________ Age at menopause: ______________

Amount of flow: ❏ Heavy ❏ Medium ❏ Light Days of flow: ______________________

Pain/Cramps: ❏ None ❏ Mild ❏ Moderate ❏ Severe

Are your periods: ❏ Regular ❏ Irregular Days from one cycle to the next: __________ Bleeding between periods? ❏ Yes ❏ No

Gynecological/Endocrine History:

Last Pap Test: ____________ Results: ______________ Last Mammogram: __________ Results: ____________

Please check below any that apply to you:

❏ Gonorrhea
❏ Chlamydia
❏ Genital Herpes
❏ Pelvic Infection
❏ Painful Intercourse
❏ Breast Discharge
❏ Breast Disease
❏ Acne
❏ Douche
❏ Abnormal PAP
❏ Vaginal Lubricants
❏ Excessive Hair Growth
❏ Did your mother take DES?
❏ Abnormal Mammogram
❏ Condyloma/Venereal Warts

Obstetrical History:

Number of Pregnancies: ____________ Full-Term Deliveries: ____________ Premature Births: ______________

Stillborn: ________________ Miscarriages: ________________ Elective Terminations: ______________

Date of Birth	Sex	Birth Weight	Duration of Pregnancy	Vaginal Delivery/C-Section	Where Delivered	Present Health

Birth Control: (If this section does not apply to you, please skip)

Current Method: ______________________ Are you satisfied with your current method? ❑ Yes ❑ No

Check those methods that you have used:

- ❑ None
- ❑ Abstinence
- ❑ Rhythm
- ❑ Diaphragm/Cervical Cap
- ❑ Condoms
- ❑ Contraceptive Foam
- ❑ Vasectomy
- ❑ Tubal Ligation
- ❑ Birth Control Pills/Patch/Vaginal Ring

Past Medical History:

Medical Illnesses: Have you ever had any of the following:

- ❑ Diabetes
- ❑ Hypertension
- ❑ Thyroid Disease
- ❑ Migraines
- ❑ Asthma/Lung Disease
- ❑ Cancer
- ❑ Blood Clots
- ❑ Kidney Disease
- ❑ Stroke
- ❑ Intestinal Disorders
- ❑ Gall Bladder Disease
- ❑ HIV
- ❑ Hepatitis
- ❑ Heart Murmer
- ❑ Rheumatic Fever
- ❑ Epilepsy/Seizure Disorders
- ❑ Gastric Ulcer/ Gastric Reflux
- ❑ Injuries/Accidents: ______________________ ______________________

Allergies: ❑ Yes ❑ No

Type: ______________________

____

Current medications that you are taking including any herbal preparations: ______________________

____

Previous Hospitalization(s) and Date(s): ______________________

____

Previous Surgeries and Dates: ______________________

____

Please check the box next to any of the following that you have had:

- ❑ Eye Disease/Impaired Sight
- ❑ Involuntary Loss of Urine
- ❑ Impaired Hearing
- ❑ Anemia
- ❑ Sinus Condition
- ❑ History of Sexually Transmitted Disease
- ❑ Dizziness/Fainting Spells
- ❑ Increased Facial Hair
- ❑ Seizures/Convulsions
- ❑ Swelling of Hands/Feet
- ❑ Paralysis
- ❑ Frequent or Severe Headaches
- ❑ Varicose Veins
- ❑ Fatigue or Weakness
- ❑ Depression/Anxiety
- ❑ Thyroid Problems
- ❑ Bladder Problems, Infection
- ❑ Skin Disorders
- ❑ Frequent Heartburn/ Stomach Ulcers
- ❑ Chronic/Frequent Cough
- ❑ Liver or Gall Bladder Disease
- ❑ Chest Pain
- ❑ Colitis or Bowel Disease
- ❑ Heart Palpitations
- ❑ Rectal Bleeding, Hemorrhoids
- ❑ Shortness of Breath
- ❑ Constipation, Diarrhea
- ❑ Kidney Disease/ Kidney Stones

Social History:

Sleep Patterns: ________________hrs/day Do you: ❏ Have difficulty falling asleep? ❏ Staying asleep?

Exercise patterns: Type(s): ____ hrs/wk__________

Leisure Activities: ____

Diet/Usual Caloric Intake: ____

Have you had a: ❏ Recent weight loss ❏ Recent weight gain If so, how many pounds?__________________

Do you smoke? ❏ Yes ❏ Never If yes, for how long? ______________ How much? __________ ❏ Quit How long ago? _____

Do you drink alcohol? ❏ Yes ❏ Never If yes, for how long? ______________ How much? __________ ❏ Quit How long ago? _____

Do you drink caffeine? ❏ Yes ❏ Never If yes, for how long? ______________ How much? __________ ❏ Quit How long ago? _____

Do you use recreational drugs? ❏ Yes ❏ Never

If yes, for how long? __________ How much? __________ ❏ Quit How long ago? ____________________

History of physical abuse ❏ Yes ❏ No History of sexual abuse ❏ Yes ❏ No

Psychosocial:

Sexual Orientation: ❏ Heterosexual ❏ Lesbian ❏ Bisexual Is religion important in your life? ❏ Yes ❏ No

Have there been any major changes in your life recently? ❏ Yes ❏ No If yes, please explain:____________________

Do you feel that you deal with stress effectively? ❏ Yes ❏ No If no, please explain____________________

Family History:

Name: ____ Date of Birth ____________________

Relative: Age, if living; Medical History (If deceased, age at time of death; Medical History/Cause of Death)

Mother: ______________________________ Father: ______________________________

Sister 1: ____________________ Sister 2: ____________________ Sister 3: ____________________

Brother 1: ____________________ Brother 2: ____________________ Brother 3: ____________________

Has anyone else in your family had any of the following? If so, indicate who by relationship. (i.e. mother, maternal grandmother, etc.):

❏ Diabetes __________ ❏ Cancer __________ ❏ Heart Disease ______________ ❏ High Blood Pressure __________

❏ Stroke __________ ❏ Seizures/Epilepsy __________ ❏ Cystic Fibrosis __________ ❏ Recurrent Miscarriage __________

❏ Sickle Cell Anemia __________ ❏ Down Syndrome __________ ❏ Early Menopause __________ ❏ Tay Sachs __________

❏ Endometriosis ________ ❏ Ovarian Cancer ______________ ❏ Breast Cancer __________ ❏ Thyroid Disease ________

❏ Psychiatric Disease __________ ❏ Other ____

Family History (Continued):

Husband/Partner History:

Number of Siblings: Sisters: ______________________ Brothers: ______________________

Has anyone else in your Husband's/Partner's family had any of the following? If so, indicate who:

❑ Diabetes __________ ❑ Cancer __________ ❑ Heart Disease __________ ❑ High Blood Pressure __________

❑ Stroke __________ ❑ Seizures/Epilepsy __________ ❑ Cystic Fibrosis __________ ❑ Recurrent Miscarriage __________

❑ Sickle Cell Anemia __________ ❑ Down Syndrome __________ ❑ Early Menopause __________ ❑ Tay Sachs __________

❑ Endometriosis __________ ❑ Ovarian Cancer __________ ❑ Breast Cancer __________ ❑ Thyroid Disease __________

❑ Psychiatric Disease __________ ❑ Other ______________________

Please check those items for which you would like more information:

❑ Smoking Cessation ❑ Acupuncture ❑ Fertility Evaluation __________

❑ Nutrition Counseling ❑ Psychological Counseling ❑ Menopause Management __________

❑ Massage Therapy ❑ Preconception Counseling ❑ Other:__________ __________