Female Medical History
Independence Park Medical Services

9500 Independence Drive, Suite 900, Anchorage, Alaska 99507
Phone (907) 522-1341 Fax (907) 522-1343

Name:_____ **Birth Date:**_____ **Date:**_____

PERSONAL MEDICAL HISTORY

Have you ever had the following:

YES	NO	
☐	☐	MIGRAINES
☐	☐	THYROID PROBLEMS
☐	☐	ASTHMA
☐	☐	BREAST DISEASE
☐	☐	HIGH BLOOD PRESSURE
☐	☐	BLOOD CLOTS (arms, legs, or lungs)
☐	☐	STROKE
☐	☐	ANEMIA OR BLOOD DISEASE
☐	☐	HIGH BLOOD FAT (cholesterol)
☐	☐	SICKLE CELL DISEASE
☐	☐	BLOOD TRANSFUSION
☐	☐	LIVER DISEASE (hepatitis or mononucleosis)
☐	☐	KIDNEY OR BLADDER PROBLEMS
☐	☐	INFECTION OF UTERUS OR FALLOPIAN TUBES
☐	☐	VAGINAL INFECTIONS
☐	☐	GENITAL WARTS
☐	☐	STD (Gonorrhea, Syphilis, Herpes)
☐	☐	IV DRUG USE
☐	☐	OVARY PROBLEMS
☐	☐	DIABETES
☐	☐	CANCER
☐	☐	PHYSICAL OR SEXUAL ABUSE
☐	☐	EMOTIONAL OR PSYCHIATRIC PROBLEMS

MEDICATIONS and DOSES

Prescription, Over the Counter, Birth Control, Vitamins and Herbs

_____
_____
_____
_____
_____
_____

ALLERGIES- Medications, skin, latex

_____
_____
_____
_____

FAMILY HISTORY-parents, grandparents, brothers, or sisters, had any of the following:

YES	NO	
☐	☐	BREAST OR OVARIAN CANCER
☐	☐	OTHER CANCERS (type_____)
☐	☐	DIABETES
☐	☐	HEART ATTACK OR STROKE
☐	☐	HIGH BLOOD PRESSURE
☐	☐	HIGH CHOLESTEROL

MENSTRUAL AND PAP HISTORY

1ST DATE OF LAST NORMAL PERIOD: _____
NUMBER OF WEEKS BETWEEN PERIODS:_____
HOW MANY DAYS DO YOU FLOW?_____
DATE OF LAST PAP SMEAR_____
HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR?
If so, when?_____
CURRENT BIRTH CONTROL METHOD_____
AGE WHEN PERIOD BEGAN_____

PREGNANCY HISTYORY

HOW MANY TIMES HAVE YOU BEEN PREGNANT?
(including now)_____
NUMBER OF LIVE BIRTHS_____
NUMBER OF MISCARRIAGES_____
NUMBER OF ABORTIONS_____
PROBLEMS WITH PREGNANCY_____
_____
_____
_____

HOSPITALIZATIONS/SURGERIES

(Dates and Reasons)

_____
_____
_____
_____

HABITS	YES	NO	AMOUNT
ALCOHOL	☐	☐	_____
TOBACCO	☐	☐	_____
RECREATIONAL DRUGS	☐	☐	_____
CAFFEINE	☐	☐	_____
EXERCISE	☐	☐	_____
MORE THAN 5 PARTNERS	☐	☐	_____

SEXUAL PARTNERS: M____ F____ BOTH _____

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OTHER SYMPTOMS

Currently: Are you having problems with: (circle)

General:	fevers / chills/ decreased energy/ weight gain/ weight loss
Ears, Nose, Throat:	sinus problems/ ringing in the ears/ sore throat
Cardiovascular:	palpitations/ chest pain/ swelling in legs
Respiratory:	shortness of breath/ chronic cough/ wheezing
Gastrointestinal:	diarrhea/ constipation/ heartburn/ rectal bleeding/ nausea/ vomiting
Genitourinary:	painful intercourse/ leaking urine/ pain with urination
Musculoskeletal:	joint pain/ back pain/ muscle weakness
Emotional:	depression/ anxiety/ emotional changes
Endocrine:	excessive thirst/ hot spells/ difficulty staying warm
Hematologic:	excessive bruising/ blood clots in veins
Other:	_____
	_____