

# PACIFIC COAST WOMEN'S HEALTH

317 N. El Camino Real, Suite 306 • Encinitas, CA 92024  
(760) 944-1000 • Fax (760) 944-1123

Patient History 1 of 2

**Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

### MENSTRUAL HISTORY

First day of last period \_\_\_\_\_  
Age at first period \_\_\_\_\_

**DO YOU HAVE:** YES NO  
Pain with period? \_\_\_\_\_  
Regular periods? \_\_\_\_\_  
Bleeding between periods? \_\_\_\_\_  
Period is: \_\_\_\_\_  
Light \_\_\_\_\_ Moderate \_\_\_\_\_ Clots \_\_\_\_\_?

**DO YOU HAVE ANY OF THE FOLLOWING BEFORE OR DURING YOUR PERIOD?** YES NO  
Cramps \_\_\_\_\_  
Nervous tension \_\_\_\_\_  
Mood swings/irritability \_\_\_\_\_  
Anxiety \_\_\_\_\_  
Weight gain \_\_\_\_\_  
Breast tenderness \_\_\_\_\_  
Craving for sweets \_\_\_\_\_  
Increased appetite \_\_\_\_\_

### GYNECOLOGICAL HISTORY

Date of last PAP smear \_\_\_\_\_  
Where was it done? \_\_\_\_\_

Was it normal? \_\_\_\_\_  
Did your mother take D.E.S while pregnant with you? \_\_\_\_\_

**HAVE YOU EVER HAD?: SEXUALLY TRANSMITTED DISEASES (STDs)** YES NO  
Gonorrhea \_\_\_\_\_  
Syphilis \_\_\_\_\_  
Chlamydia \_\_\_\_\_  
Genital Herpes \_\_\_\_\_  
Genital Warts \_\_\_\_\_

**VAGINAL INFECTIONS**  
Trichomonas \_\_\_\_\_  
Yeast (Monilia) \_\_\_\_\_  
Gardnerella \_\_\_\_\_

**UTERINE ABNORMALITIES**  
Infection of the tubes/uterus \_\_\_\_\_  
Uterine fibroids \_\_\_\_\_  
Ovarian cysts \_\_\_\_\_  
Endometriosis \_\_\_\_\_  
Cervicitis \_\_\_\_\_

**CANCER OF:**  
Ovaries \_\_\_\_\_  
Vulva \_\_\_\_\_  
Vagina \_\_\_\_\_  
Uterus \_\_\_\_\_  
Breasts \_\_\_\_\_

### PERSONAL MEDICAL HISTORY

**HAVE YOU EVER HAD:** YES NO  
Eye problems \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Thyroid problems \_\_\_\_\_  
Cancer \_\_\_\_\_  
Heart Disease \_\_\_\_\_  
Breast disease/mass \_\_\_\_\_  
Stroke \_\_\_\_\_  
Anemia \_\_\_\_\_  
Bladder or Kidney disease \_\_\_\_\_  
Depression \_\_\_\_\_  
Epilepsy \_\_\_\_\_  
Gallbladder disease \_\_\_\_\_  
High blood pressure \_\_\_\_\_  
Liver disease/Hepatitis \_\_\_\_\_  
Pancreatitis \_\_\_\_\_  
Thrombophlebitis \_\_\_\_\_  
Migranes \_\_\_\_\_  
Blood vessel clots \_\_\_\_\_  
Lung disease \_\_\_\_\_  
Rubella/Immunization \_\_\_\_\_

### SEXUAL HISTORY

Age of first intercourse \_\_\_\_\_

**ANSWER THE FOLLOWING** YES NO  
Are you currently sexually active? \_\_\_\_\_  
Partner with painful urination? \_\_\_\_\_  
Have you had a new partner in the last two months? \_\_\_\_\_  
Has your partner had a new partner in the last two months? \_\_\_\_\_  
Do you have pain during intercourse? \_\_\_\_\_  
Bleeding/spotting during intercourse? \_\_\_\_\_  
Do you practice anal sex? \_\_\_\_\_  
Frequency of sex/week? \_\_\_\_\_

### OBSTETRICAL HISTORY

**NUMBER OF:**  
Pregnancies \_\_\_\_\_  
Abortions \_\_\_\_\_  
Premature births \_\_\_\_\_  
Still births \_\_\_\_\_  
Living children \_\_\_\_\_  
Neonatal deaths \_\_\_\_\_  
Miscarriages \_\_\_\_\_  
Ectopic pregnancies \_\_\_\_\_  
Molar pregnancies \_\_\_\_\_  
Complications of pregnancies and/or delivery: \_\_\_\_\_

# PACIFIC COAST WOMEN'S HEALTH

317 N. El Camino Real, Suite 306 • Encinitas, CA 92024  
(760) 944-1000 • Fax (760) 944-1123

Patient History 2 of 2

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

## CONTRACEPTIVE HISTORY

WHICH BIRTH CONTROL METHODS  
HAVE YOU USED:

	YES	NO
Abstinence	_____	_____
Pill	_____	_____
IUD	_____	_____
Diaphragm	_____	_____
Condom	_____	_____
Foam/other Spermicides	_____	_____
Sponge	_____	_____
Rythm	_____	_____
Natural Family Planning	_____	_____
Fertility Awareness	_____	_____
Vasectomy	_____	_____
Tubal ligation	_____	_____
Cervical cap	_____	_____
Depo Provera (Injection)	_____	_____
Withdrawal	_____	_____
Other Method	_____	_____
None	_____	_____

Problems \_\_\_\_\_  
Side Effects \_\_\_\_\_  
Failures/Reasons \_\_\_\_\_

## FAMILY MEDICAL HISTORY

HAS ANYONE IN YOUR FAMILY  
HAD ANY OF THE FOLLOWING?:

	YES	NO	RELATIVE
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
Stroke	_____	_____	_____
Sickle cell anemia	_____	_____	_____
Alcoholism	_____	_____	_____
Tuberculosis	_____	_____	_____
Inherited genetic disease	_____	_____	_____
Mental retardation	_____	_____	_____
Tay Sachs disease	_____	_____	_____
Downs syndrome	_____	_____	_____
PKU	_____	_____	_____
High blood pressure	_____	_____	_____

	YES	NO
Do you have any allergies?	_____	_____
Are you on any medication?	_____	_____
Do you have any problem with medications that you would like to discuss?	_____	_____

WHAT KIND?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## HOSPITALIZATION AND SURGICAL HISTORY

	YES	NO
Hospitalizations	_____	_____
Surgeries	_____	_____

REASON, WHEN?  
\_\_\_\_\_  
\_\_\_\_\_

## HABITS

	YES	NO
Do you smoke cigarettes?	_____	_____
Consume alcoholic beverages?	_____	_____
Do you use illegal drugs?	_____	_____
Do you have any problems/concerns that you wish to discuss today?	_____	_____

HOW MANY, WHAT TYPE?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Clinician Comments: \_\_\_\_\_  
\_\_\_\_\_