



# Camelback Women's Health

Name- Last, First, MI:	Date of Birth:	Today's Date:
Occupation:	Marital Status:	Age:
What is the reason you are being seen today?		
How long have you lived in AZ?	What brought you to AZ?	

- How old were you when you started having periods? \_\_\_\_\_
- What day did your last period start? \_\_\_\_\_ When was your last normal period? \_\_\_\_\_
- How many days does your period normally last? \_\_\_\_\_ How many days between periods? \_\_\_\_\_
- Describe your menstrual flow- check one:  light  moderate  heavy Clots?  yes  no
- Are you presently sexually active?  yes  no
- Are you using anything to prevent pregnancy?  yes  no If yes, which method? \_\_\_\_\_
- Any problems with your current method? \_\_\_\_\_
- Do you have any pelvic pain?  yes  no Pain with intercourse?  yes  no
- Have you ever had a sexually transmitted disease?  yes  no
- If yes to #9- please check and give date of onset:  Herpes: \_\_\_\_\_ Genital Warts: \_\_\_\_\_  
 Gonorrhea: \_\_\_\_\_  Syphilis: \_\_\_\_\_  Chlamydia: \_\_\_\_\_  Other: \_\_\_\_\_
- Do you smoke?  yes  no In the past?  yes  no Packs per day? \_\_\_\_\_ How long? \_\_\_\_\_
- Do you use alcohol?  yes  no In the past?  yes  no Type? \_\_\_\_\_ How much? \_\_\_\_\_
- Have you ever been told you should or have you ever sought help for chemical dependency?  yes  no
- Are you in a high risk category for HIV?  yes  no Have you been tested?  yes  no
- Do you have any urinary problems?  no  involuntary loss  pain with urination  frequency
- Have you ever been pregnant?  yes  no If yes, please list all pregnancies with outcome:

**A-** Abortion    **M-** Miscarriage    **ND-** Normal Delivery    **CD-** Complicated Delivery (List Complications)

	Month/ year	Outcome	Complications		Month/ year	Outcome	Complications
1				5			
2				6			
3				7			
4				8			

**Lab Testing:** Please list date of last testing

Mammogram When? \_\_\_\_\_ Where? \_\_\_\_\_ History of abnormal mammgram? \_\_\_\_\_

Chest x-ray When? \_\_\_\_\_ Where? \_\_\_\_\_

Cholesterol When? \_\_\_\_\_ Where? \_\_\_\_\_

Pap Smear When? \_\_\_\_\_ Where? \_\_\_\_\_ History of abnormal paps? \_\_\_\_\_

**Drug allergies:** Please list individually and type of reaction...If none, write none

**Medications:** Including prescription and over the counter- Please list all with dosage and frequency

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

**Past Medical History:** Check all applicable and list age of onset- Please indicate any illness you are being seen for on a regular basis.

Polio \_\_\_\_\_ Diabetes \_\_\_\_\_ Mononucleosis \_\_\_\_\_ Mental Illness \_\_\_\_\_ Bronchitis \_\_\_\_\_ Eczema \_\_\_\_\_

Liver Disease \_\_\_\_\_ Eye Trouble \_\_\_\_\_ Pneumonia \_\_\_\_\_ Hemorrhoids \_\_\_\_\_ Ear Trouble \_\_\_\_\_

Valley Fever \_\_\_\_\_ Emphysema \_\_\_\_\_ Ulcers \_\_\_\_\_ Hernia \_\_\_\_\_ Kidney Disease \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_ Arthritis \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Thyroid Disease \_\_\_\_\_ Depression \_\_\_\_\_

Heart Disease \_\_\_\_\_ Osteoporosis \_\_\_\_\_ Other \_\_\_\_\_

**Surgeries:** Date Type Outcome Where

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**Hospitalizations:** Other than pregnancy or surgeries

Date Reason

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**Family History:** Check if any blood relative has ever had any of the following illnesses:

Cancer Type: \_\_\_\_\_ Thyroid Trouble  Allergies  High Blood Pressure

Epilepsy  Stroke  Heart Trouble  Mental Illness  Blood Disease

**State of Health:** If deceased, give age of death and cause

Father \_\_\_\_\_

Mother \_\_\_\_\_

Brothers and Sisters \_\_\_\_\_

Children \_\_\_\_\_