Colorado Complete Health for Women
Adult Health History

Patient Name ______________________________ *Age* ____________ *Date* ________

Welcome to our practice. Please fill out the information found below to the best of your ability.

Date of Birth: ______________ *PCP:* ____________________________________

Chief Complaint: ____

Preferred Pharmacy: ____

Have you ever had the following and if so, please include date of diagnosis: (Circle "no" or "yes")

Anemia .... no yes	Back Trouble .... no yes	High Blood Pressure .... no yes
Blood Transfusion ...... no yes	Migraine Headaches ..... no yes	Tuberculosis or Positive TB Skin Test .... no yes
Chickenpox .... no yes		
Diabetes .... no yes	Asthma .... no yes	Cancer .... no yes
Pneumonia .... no yes	Bleeding Tendency .... no yes	If yes, what kind__________
Heart Problems........ no yes	Hernia .... no yes	Hepatitis .... no yes
Ulcer .... no yes	Kidney Disease .... no yes	Thyroid Disease .... no yes
Birth Defects or Inherited Diseases ... no yes	Arthritis or Lupus .... no yes	
	Seizure Disorder .... no yes	

Other Past Medical History: Please list your medical problems and what year they were diagnosed.

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Previous Hospitalizations/Surgeries/Serious Illnesses (Do not include pregnancies here)	*When*	*Complications*

Medications: (including nonprescription like supplements, herbs, vitamins, etc.)

* Please include dosage and number of times taken per day (i.e. Metformin 500mg 2 tablets twice daily) *

____________________ ____________________ Vaccinations:

____________________ ____________________ TDaP (Tetanus) ___

____________________ ____________________ Influenza ___

____________________ ____________________ Gardasil ___

Drug Allergies: ______________ Other Allergies: __________

Social History:

Occupation: ______________________________

Marital status Single:___ Married:___ Separated:___ Divorced:___ Widowed:___

Use of alcohol Never:___ Rarely:___ Occasional:___ Daily:___

Use of tobacco Never:___ Previously, but quit:______ Current packs/day:_____

Use of recreational drugs Never:___ Type/Frequency:________________________

Family Medical History: * Has any family member ever had breast, cervical, uterine, ovarian or colon Cancer .... no yes

If yes, who and what type ____

Other: ____

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MD Reviewed ______________

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Review of Systems: Please indicate if you have any of the following symptoms currently:

☐ **Constitutional Symptoms**
- Good general health lately . . . no yes
- Recent weight change . . . . . . no yes
- Fever . . . . no yes
- Fatigue . . . . no yes

☐ **Eyes**
- Eye disease or injury . . . . no yes
- Wear glasses/contacts . . . . . .no yes
- Blurred or double vision . . . . . no yes

☐ **Ears/Nose/Mouth/Throat**
- Hearing loss or ringing . . . . . . no yes
- Earaches or drainage . . . . no yes
- Chronic sinus problems . . . . . .no yes
- Nose bleeds . . . . .no yes
- Mouth sores . . . . no yes
- Bleeding gums . . . . no yes
- Bad breath or bad taste . . . . .no yes
- Sore throat or voice change . .no yes
- Swollen glands in neck . . . . . . .no yes

☐ **Cardiovascular**
- Heart trouble . . . . .no yes
- Chest pain or Angina . . . . no yes
- Palpitations . . . . .no yes
- Shortness of breath w/ walking Or lying flat . . . . .no yes
- Swelling feet, hands, ankles . . no yes

☐ **Respiratory**
- Persistant cough over 3wks . . .no yes
- Spitting up blood . . . . no yes
- Shortness of breath . . . . no yes
- Wheezing . . . . no yes

☐ **Gastrointestinal**
- Loss of appetite . . . .no yes
- Change in bowel movements . . no yes
- Nausea or vomiting . . . . no yes
- Diarrhea . . . . no yes
- Pain bowel movements . . . . no yes
- Constipation . . . . .no yes
- Rectal bleeding/blood in stool no yes
- Gallbladder disorder . . . . no yes

☐ **Genitourinary**
- Frequent urination . . . . .no yes
- Burning/painful urination . . . . no yes
- Blood in urine . . . . no yes
- Incontinence or dribbling . . . . no yes
- Kidney stones . . . . no yes

☐ **Musculosketal**
- Joint Pain . . . . no yes
- Joint stiffness/swelling . . . . . no yes
- Weakness of muscles/joints . .no yes
- Muscle pain or cramps . . . . . . .no yes
- Back Pain . . . . .no yes
- Cold extremities . . . . .no yes
- Difficulty in walking . . . . no yes

☐ **Integumentary (skin, breast)**
- Rash or itching . . . . no yes
- Change in skin color . . . . no yes
- Change in hair or nails . . . . . . no yes
- Varicose veins . . . . .no yes
- Breast pain . . . . no yes
- Breast discharge . . . . no yes

☐ **Neurological**
- Frequent/Recurring headaches . .no yes
- Lightheaded or dizzy . . . . no yes
- Convulsions or seizures . . . . .no yes
- Numbness or tingling . . . . no yes
- Tremors . . . . no yes
- Head injury. . . . . no yes

☐ **Psychiatric**
- Memory loss or confusion . . . . . . no yes
- Nervousness . . . . no yes
- Depression . . . . .no yes
- Insomnia . . . . no yes

☐ **Endocrine**
- Glandular or hormone problem . . no yes
- Excessive thirst or urination . . . .no yes
- Heat or cold intolerance . . . . no yes
- Skin becoming drier . . . . .no yes
- Loss in height . . . . no yes

☐ **Hematologic/Lymphatic**
- Slow to heal after cuts . . . . .no yes
- Bleeding/bruising tendency . . . . . no yes
- Anemia . . . . no yes
- Past transfusion . . . . .no yes
- Enlarged glands . . . . no yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:
- Penicillin . . . . no yes
- Other antibiotics . . . . .no yes
- Morphine, Demerol, or other narcotics . . . . .no yes
- Novacain/anesthestics . . . no yes
- Aspirin or other pain meds no yes
- Tetanus antitoxin . . . . .no yes
- Iodine . . . . no yes
- IV Contrast . . . . .no yes
- Other drugs/medications: no yes

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Obstetrical History:

Please list the number of Total Pregnancies _____

Premature births _____ Miscarriages_____ Abortions_____ Living Children_____

No.	Born Mo/Yr	Weight Lb/Oz	Sex F/M	Weeks Preg. (40 = term)	Type of Delivery	Complications Yes	Complications No
1	____/____	___/___	___	______	__________	___	___
2	____/____	___/___	___	______	__________	___	___
3	____/____	___/___	___	______	__________	___	___
4	____/____	___/___	___	______	__________	___	___

Menstrual History:

Age when periods started _____ How many days from start of 1 period to start of next _____

Number of days menstrual flow lasts _____ Flow is: Light____ Medium____ Heavy____

Number of (pads ____ Tampons ____) used on heaviest day ______

Periods are: Regular _____ Irregular ____ Absent _____

Cramping: None ____ Mild ____ Severe ____ Medication taken for cramping:__________

Spotting between periods: None _____ Occasionally ______ Always ______

Bleeding with or after intercourse? __________ Date of last normal menstrual period: ________

If post-menopause, age at time of menopause __________

Problems with type of birth control used: _______ Are you currently sexually active? Yes or No

Gynecologic History: Have you ever had:

Pelvic infection . . . . no yes

Venereal infection ("VD") . . . . . no yes
(Gonorrhea, Chlamydia, HPV, Syphilis)

Genital warts . . . . no yes

Cervical Surgery (freezing, laser, LEEP) . . . . no yes

Ovarian cyst(s) . . . . no yes

Ovary (ies) removed . . . . no yes

Bladder or rectal repair surgery . . no yes

Breast lump or biopsy . . . . no yes

Hormone replacement therapy . no yes
(at any time)

Vaginal infection . . . . no yes

Herpes . . . . no yes

Abnormal Pap smear . . . . no yes

Hysterectomy . . . . no yes

Ectopic (tubal) pregnancy . . . no yes

Problem with excess hair . . . no yes

Loss of urine w/coughing or straining . . . . no yes

Symptoms of hot flash, night sweats, vaginal dryness, or insomnia . . . . no yes

Approximate date of last pap smear __________

Approximate date of last pelvic exam __________

Approximate date of last mammogram __________

Approximate date of last DEXA __________

Approximate date of last colonoscopy ________

Approximate date of last bone density test __________

- OVER -

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Other History:

We want to be available to assist our patients with problems or questions about sexuality, abuse, and domestic violence. The information you provide may be related to certain medical conditions as well. We encourage all of our patients to feel free to discuss such issues. This, as with all medical information, is treated with strict confidence. Please answer each question only if you feel comfortable doing so.

Intercourse is painful . . . . no yes
My sexual interest is less than I/my partner would like . . . . no yes
I would like a referral for sexual counseling . . . . no yes
I am presently or in the past involved in an
Abusive/violent relationship . . . . no yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform necessary services I may need.

______________________________ ______________
Signature of patient, parent, or guardian **Date**

- OVER -

MD Reviewed ______________