Women's Healthcare Associates, LLC

REVIEW OF MEDICAL HISTORY

Adolescent Health Visit

Please answer the following questions

Date______________________

Name____ Age___________ Date of Birth_____________________

By what name do you like to be called? ___________________

Do you want a female attendant in your room during your exam? Y N

Referred by___________________________

Menstrual History

How old were you when you had your first period? _______________________

What was the first day of your most recent period? _______________________

Are your periods regular? _______________________

How many days from the first day of one period to the first day of the next? _______________________

How many days do you flow? _______________________ How heavy do you flow? _______________________

Are your periods painful? Y N

If yes:

Do you miss school? Y N How many days? ___________

Do you miss other activities? Y N

Does anything make the pain better? ____

Does anything make the pain worse? ____

Any changes in your bowel movements with your periods? Y N

Have they always been painful? Y N

Do you have PMS symptoms? Y N

If yes, circle all that apply: bloating, headaches, food cravings, change in appetite, feeling tired, breast tenderness, crying, sadness, irritability, depression, overly sensitive, withdrawing from family and friends

Does your mother or sister(s) have menstrual problems? Y N

Medical History

Do you have any allergies to medications? Y N If so, please list here:

____

____

Are you currently taking any medication? Y N If so, please list regular meds (including over the counter drugs):

____

____

Have you had the HPV vaccine series? Y N Not sure

Have you had Hepatitis B vaccine series? Y N Not sure

Are you currently seeing a therapist? Y N If yes, who do you see?

____

____

Have you ever received medication for depression? Y N

If yes, what?____

Surgery

Please list date and nature of hospitalization below.

Operations	**Hospitalization for illness or injury**
1)________________	1)________________
2)________________	2)________________
3)________________	3)________________

Do you have any chronic or serious illnesses? Y N

If yes, please list:________________

General Physical Condition or Problems

Do you have any problems with any of the following? If yes, please list below.

Hearing, Eyes, Ears, Nose, Throat	Y N	Hepatitis or any kind of liver ailment or jaundice	Y N
Heart problems or high blood pressure	Y N	Kidney or bladder problems/leaking of urine	Y N
Lung problems/Asthma/Bronchitis	Y N	Anemia/blood disorder/transfusion	Y N
Breast lumps/pain/nipple discharge	Y N	Thyroid problems/diabetes/other endocrine problems	Y N
Stomach/bowel/gall bladder problems	Y N	Headaches/migraines/nervous disorder	Y N
Varicose veins or phlebitis	Y N	Chicken Pox	Y N

Other________________

____

Family History

Who in your family have any of the following?

High Blood Pressure	Y	N	________	Breast Cancer or Breast Disease	Y	N	________
Stroke	Y	N	________	Colorectal Cancer	Y	N	________
Heart Problems	Y	N	________	Ovarian Cancer	Y	N	________
Kidney Problems	Y	N	________	Hepatitis/TB/any other infectious disease	Y	N	________
Diabetes	Y	N	________	Bleeding Disorders	Y	N	________

Other

____

____

Do you have any other issues you wish to discuss? Y N

Please list here:

____

____

____