Barton
Women's Health

Health Questionnaire

Name_____ **Date**___/___/_____ **Age**____

Reason for Visit: □ Annual □ Referral □ Other _____

Pregnancies:
Total number of pregnancies: _____
Miscarriages: _____ Abortions: _____ Births: _____

General Health Information:
First day of last menstrual period: ___/___/_____ OR □ menopausal
Last pap smear (month/year): ___/_____ OR □ never done
Last mammogram (month/year): ___/_____ OR □ never done
Contraception: _____
Last colonoscopy (month/year): ___/_____ OR □ never done
Last bone density (month/year): ___/_____ OR □ never done

Vaccinations:
Last Influenza (month/year): ___/_____ OR □ never done
Gardasil (month/year): ___/_____ OR □ never done
(for <35 years of age)

Gynecological Problems:
□ None □ Abnormal bleeding □ Pelvic pain □ Urinary problems □ Pregnancy
□ Vaginal irritation/discharge □ Hormonal □ Other

Gynecological History:
Age menses started: _____
Menses: □ not applicable
Interval: □ 28-day cycle □ ____day cycle □ Irregular
Duration: _____ days
Flow: □ light □ medium □ heavy □ heavy with clots
Pain with menses: □ none □ mild □ moderate □ severe
Exposure to STDs: □ No □ Yes
History of abnormal pap: □ No □Yes

Pregnancy History: □ Never been pregnant
1 preg: □ miscarriage □ abortion □ vag □ C-sec year:_____ weight: _____
2 preg: □ miscarriage □ abortion □ vag □ C-sec year:_____ weight: _____
3 preg: □ miscarriage □ abortion □ vag □ C-sec year:_____ weight: _____
4 preg: □ miscarriage □ abortion □ vag □ C-sec year:_____ weight: _____
5 preg: □ miscarriage □ abortion □ vag □ C-sec year:_____ weight: _____

Past Medical History: Primary Care Physician: _____ ***OR*** □ None
Current Medical Problems: □ None
□ Anemia □ Asthma □ Diabetes □ Depression □ High Blood Pressure
□ High Cholesterol □ Hypothyroidism □ Other_____

Surgical History:
Gynecological Surgeries: □ ***None***
1st surgery: Type:_____ Year:_____
2nd surgery: Type:_____ Year:_____
3rd surgery: Type:_____ Year:_____
4th surgery: Type:_____ Year:_____
5th surgery: Type:_____ Year:_____
Other Surgeries: □ ***None***
1st surgery: Type:_____ Year:_____
2nd surgery: Type:_____ Year:_____
3rd surgery: Type:_____ Year:_____
4th surgery: Type:_____ Year:_____
5th surgery: Type:_____ Year:_____

Allergies to Medications: □ None Known □Yes_____

Medications: □ None
Prescription: _____
Over the Counter: _____

Family History:
Father: □ Alive □ Deceased
Health Problems:_____
Mother: □ Alive □ Deceased
Health Problems:_____
Siblings: □ None Number:_____
Health Problems:_____

Social History:
Martial Status: □ Married □ Single □ Divorced □ Separated □ Engaged □ Widowed
Sexual History: □ Currently Active □ Not Currently Active □ None □ History of Abuse
Tobacco Use: □ Never □ Current (amount) _____ □ Past (year quit) _____
Alcohol Use: □ Seldom/rare □ Current (amount) _____ □ Previous User (year quit) _____
Caffeinated Beverages: □ Never □ Current (amount)_____
Other Drug Use: □ Marijuana □ Cocaine □Amphetamines □ IV drugs □ Prescription drugs
□ History of Substance Abuse □ Other_____

Are you currently having problems or have questions about the following:

Weight change	_____	Diet	_____
Skin changes	_____	Problems with urination	_____
Ear, sinus or vision	_____	Constipation	_____
Chest pain	_____	Headaches	_____
Irregular heartbeat	_____	Depression	_____
Cholesterol	_____	Pelvic pain	_____
Stomach problems	_____	Abnormal bleeding	_____
Any other problems?	_____	Coughing or shortness of breath	_____