The Birth Center: Holistic Women's Health Care, L.L.C.

Medical History

(All information is confidential)

Name:_____ Date of Birth: ____/____/____ Height:_____ Date:___/___/____

General

Who is your primary care provider?

_____

Are you allergic to any medications, drugs, Latex, or other substances? If so what?	Yes	No
Are you currently or have you ever been treated for any major illness/conditions? If so what?	Yes	No
Have you ever had any surgeries or been hospitalized? If yes, why?	Yes	No
Are you now or do you frequently take any over–the-counter or prescription medications or vitamins/supplements? If yes, please list: _____ _____	Yes	No
Have you ever received blood or blood products? If yes, when? _____ Did you have any reactions?	Yes	No

Family History

List any of your immediate biological family who has had any of the following.

Cancer: What Kind? _____
Tuberculosis:
Diabetes:
High Blood Pressure:
Heart Disease:
Stroke:
Sickle Cell Disease or Trait:
Osteoporosis/Osteopenia:
Blood Clots:
Other:

Please Circle if you have had any of the following:

Acne

Headaches

Blurred or double vision unless corrected by glasses

Dizziness

Anxiety/Depression

Mental/Emotional Conditions

Epilepsy/Seizures

Hirsutism (Excess Hair)

Thyroid Problems

Lung Problems

Heart Problems (including Rheumatic Fever)

High Blood Pressure

Blood Clots

Varicose Veins

Anemia

Blood Disease

High Cholesterol

Sickle Cell Anemia

Diabetes

Back Problems

Major Accidents

Broken Bones

Kidney Infection

Bladder Infection

Trouble Holding Urine

Rectal Bleeding or Blood in Stool

Liver Conditions (including Hepatitis or Jaundice)

Other:

Social History

Do you drink alcohol? How much?/How often? _____ Do you feel you have a problem with alcohol use?	Yes Yes	No No
Do you smoke tobacco? How much?/How often? _____ Are you interested in quitting smoking?	Yes Yes	No No
Do you use "recreational" drugs? (Marijuana, cocaine, LSD, ecstasy, etc.) If yes, what drug and how often? _____ _____ Do you feel that you have a problem with drugs? Does anyone close to you have a problem with drugs?	Yes Yes Yes	No No No
Have you ever been physically, verbally, mentally, or sexually abused by anyone?	Yes	No
Are you currently in a relationship in which you feel in danger?	Yes	No

Breast

Does anyone in your family have a history of breast cancer? If yes, who? _____	Yes	No
Do you do self-breast exams?	Yes	No
Have you ever had a breast exam by a healthcare provider?	Yes	No
Have you ever had a breast lump?	Yes	No
Have you ever had a mammogram? If yes, when was the last? ____/____/____	Yes	No

Menstrual History

At what age did you start your period? _____		
Are you post-menopausal? If yes when was your last period? __/___/___ If yes, have you used or are you currently using hormone replacement?	Yes Yes	No No
First day of you last menstrual period? Date: ___/___/___		
Was this a normal period for you?	Yes	No
Number of days between periods? _____		
How many days in your flow? _____		
Is your flow: Light Medium Heavy		
Do you frequently have PMS Symptoms?	Yes	No
If yes what are your symptoms?		

Pregnancy History

Could you be pregnant now?	Yes	No
Have you ever been pregnant?	Yes	No
If yes, how many pregnancies? _____		
Number of living children: _____		
Any complications with your pregnancies or births?		

Sexual History

Date if last PAP: ____/____/____		
Have you ever had an abnormal PAP? If yes, explain:	Yes	No
Have you ever had sex?	Yes	No
Have you had sex with: Men Women Both		
Do you have a current partner?	Yes	No
If yes is your partner a woman or a man? _____		
How many sexual partners have you had in the past year? _____		
Have you ever had a sexually transmitted infection?	Yes	No
If yes, circle all that apply: Trichomoniasis Herpes Gonorrhea Chlamydia Hepatitis Syphilis Genital Warts/HPV HIV/AIDS Other:_____		
Have you had a vaginal infection such as bacterial vaginosis (BV) or yeast infections? If yes circle which one.	Yes	No
Do you have a need for birth control?	Yes	No
If no, I don't need birth control because:		
If yes, are you currently using birth control? Which method? _____ What methods have you used in the past? _____ Any problems with any birth control methods? _____ What methods are you interested in using? _____		
Have you ever had pain bleeding with sex?	Yes	No
I would like to discuss:		

Client Signature: _____ Clinician Signature: _____