UW Medicine
NORTHWEST HOSPITAL & MEDICAL CENTER
MERIDIAN WOMEN'S HEALTH

Patient Label

Health History Form

NAME: Last _____ **First** _____ **MI**_____ **Gender:** _____

PREFERRED PHARMACY: _____

REASON FOR VISIT: _____

Allergies: _____ **Reaction:** _____

_____ _____

_____ _____

Current Medications:	**Label – Name**	**Dose**	**Frequency**
OR			
☐ See Attached List			

Social History

☐ Single ☐ Married (name: _____) ☐ Domestic Partner (name: _____)

Do you use tobacco products? ☐ Daily ☐ Some Days ☐ Quit ☐ Passive (around cigarette smoke) ☐ Never
Packs per Day _____ Years Smoked _____ Date Quit _____
Type(s) of Tobacco: ☐ Cigarettes ☐ Cigars ☐ E-Cigarettes ☐ Chew ☐ Snuff

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit Date Quit _____
Drinks per Day _____ Drinks per Week _____ Type: ☐ Beer ☐ Wine ☐ Liquor

Do you use recreational drugs? ☐ Never ☐ Yes – Use per Week _____ ☐ No ☐ Quit Date Quit _____
Have you ever used intravenous (IV) drugs: ☐ Yes ☐ No
Types: ☐ Cocaine ☐ Marijuana ☐ Methamphetamines ☐ Stimulants ☐ Heroin
☐ Depressants (downers) ☐Hallucinogens (LSD, mushrooms) ☐ Opioids

Are you sexually active? ☐ Yes ☐ No Partners: ☐ Male ☐ Female ☐ Both # Partners This Year: _____
Birth Control: _____

Are you working? ☐ Yes What do you do? _____ ☐ No ☐ Retired ☐ Disabled

Women's Health

	Yes	No	
Never Pregnant	☐	☐	# of pregnancies_____ # deliveries_____ # full term births_____
Currently Pregnant	☐	☐	# of weeks _____
			Any problems with pregnancy? _____
Menstrual Period	☐	☐	First day of last period _____ Period occurs every _____days
			Age of first period _____
			Cramps: ☐ Mild ☐ Moderate ☐ Severe
			Flow: ☐ Light ☐ Moderate ☐ Heavy
			Spotting between periods: ☐ Yes ☐ No
Menopause	☐	☐	Age _____
			If menopausal, have you ever used a hormone replacement?
			☐ Yes ☐ No If so, what was used? _____

Health Maintenance

Pap Smear	☐	☐	Date _____
Mammogram	☐	☐	Date _____
Colonoscopy	☐	☐	Date _____
Last STD Test	☐	☐	Date _____

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Medical History — Please check box for those conditions you have now or have ever had

- ☐ No Past Medical History
- ☐ Abnormal Pap
- ☐ Abnormal Uterine Bleeding
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ CHF
- ☐ Clotting Disorder
- ☐ COPD
- ☐ Coronary Atherosclerosis
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Genital Herpes
- ☐ Genital Warts
- ☐ GERD
- ☐ Headaches
- ☐ Hepatitis
- ☐ HIV
- ☐ Hypertension
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Lipid/Cholesterol
- ☐ Migraine
- ☐ Osteoporosis
- ☐ Pelvic Pain
- ☐ PID
- ☐ Pulmonary Embolism
- ☐ Rash or Skin Problem
- ☐ Seizures
- ☐ Sexual Transmitted Infection
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Urinary Incontinence
- ☐ Urinary Tract Infection

☐ Other (Please list.): _____

_____

Surgical History — Please check box for any surgery you have had, indicate the year

- ☐ No Past Surgical History
- ☐ Abdomen Surgery
- ☐ Appendectomy
- ☐ Bladder Suspension
- ☐ Breast Surgery
- ☐ C-SECTION
- ☐ Cervical Conization
- ☐ Cervical Dysplasia Treatment
- ☐ Colon Surgery
- ☐ Colporrhaphy
- ☐ Colposcopy
- ☐ Cosmetic Surgery
- ☐ D&C
- ☐ Endometrial Ablation
- ☐ Essure Sterilization
- ☐ Gall Bladder Removal
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Hysteroscopy
- ☐ Induced Abortion
- ☐ LEEP
- ☐ Mastectomy
- ☐ Myomectomy
- ☐ Ovary Removal
- ☐ Pelvic Laparoscopy
- ☐ Tonsillectomy
- ☐ Tubal Ligation

☐ Other (Please list): _____

_____

Family History–Check all that apply

Relationship	First Name	Status (circle)	No Family History	Birth Defects	Blood Clots	Breast Cancer	Colon Cancer	Ovarian Cancer	Prostate Cancer	Diabetes	Endometriosis	Fibroids	Heart Disease	Hyperlipidemia	Hypertension	Thyroid Disease	Osteoporosis	Other: _____
Mother		alive deceased																
Father		alive deceased																
Sister		alive deceased																
Brother		alive deceased																
Maternal Grandmother		alive deceased																
Maternal Grandfather		alive deceased																
Paternal Grandmother		alive deceased																
Paternal Grandfather		alive deceased																
Maternal Aunt		alive deceased																
Maternal Uncle		alive deceased																
Paternal Aunt		alive deceased																
Paternal Uncle		alive deceased																

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Screening

In the past two weeks, how often have you been bothered by the following? (Please circle one response per statement.)

Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed, or hopeless	Not at all	Several days	More than half the days	Nearly every day

Have you fallen in the past year? ☐ Yes ☐ No
Are you afraid of falling? ☐ Yes ☐ No
Do you have issues with balance or feeling unsteady? ☐ Yes ☐ No
Do you feel safe at home? ☐ Yes ☐ No

Immunizations

	Yes	No		
HPV	☐	☐	When _____	Where _____
Flu	☐	☐	When _____	Where _____
Pneumonia	☐	☐	When _____	Where _____
TDAP	☐	☐	When _____	Where _____
Tetanus	☐	☐	When _____	Where _____

Review of Systems (current symptoms) – please check only if these are bothering you at this time

Gastrointestinal
☐ Poor Appetite ☐ Nausea ☐ Vomiting ☐ Heartburn/Indigestion ☐ Rectal Bleeding
☐ Stomach Pain ☐ Constipation ☐ Vomiting Blood ☐ Black Tarry Stools ☐ Other: _____
☐ Diarrhea ☐ Abdominal Swelling ☐ Trouble Swallowing ☐ Other: _____ ☐ Other: _____

Constitutional ☐ Fevers ☐ Fatigue ☐ Night Sweats/Hot Flashes ☐Weight Gain ☐ Weight Loss

Head / Eyes ☐ Cataracts ☐ Dry Eyes ☐ Poor Vision ☐ Color Blindness

Ears/Nose/Mouth/Throat
☐ Hearing Loss ☐ Chronic Sinus Congestion
☐ Heavy Snoring ☐ Bad Teeth

Respiratory (lungs)
☐ Cough ☐ Asthma
☐ Shortness of Breath ☐ Emphysema (COPD)

Heart ☐ Chest Pain ☐ Palpitations ☐ Irregular Heart Beat ☐ High Blood

Genitourinary ☐Sexual Problems ☐ Burning with Urination ☐ Vaginal Discharge ☐ Blood in Urine ☐ Leakage of Urine ☐ Pelvic Pain

Muscles/Bones ☐ Chronic Pain ☐ Muscle Wasting ☐ Arthritis ☐ Muscle Weakness ☐ Muscle Cramping ☐ Joint Pain

Skin ☐ Rash ☐ Jaundice ☐ Itching ☐ Psoriasis

Neurological ☐ Headaches ☐ Seizures ☐ Confusion ☐ Tremor (shaking)

Vascular ☐ Blood Clots ☐ Varicose Veins

Psychosocial
☐ Anxiety / Nerves ☐ Abusive Relationship ☐ Sexual Difficulties ☐ Insomnia ☐ Alcohol Use
☐ Depression ☐ Feeling Worthless ☐ Want to Hurt Yourself ☐ Want to Hurt Others ☐ Drug Use

Endocrine ☐ Hot Flashes ☐ Intolerance to Heat ☐ Excessive Thirst ☐ Intolerance of Cold

Blood / Lymph ☐ Swollen Lymph Nodes ☐ Easy Bruising ☐ Easy Bleeding