Crossroad Health Center Women's Health History Form

Name: Date of Birth:

PERSONAL HISTORY *(circle any of the following that you have had in the past)*

HYSTERECTOMY if so, when? _____ what for? _____

PAP SMEAR if so, when? _____ where? _____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

MAMMOGRAM if so, when? _____ where? _____

FAMILY HISTORY *(circle any of the following a family member has had in the past)*

BREAST CANCER

Who? _____

Age at diagnosis: _____

GYNECOLOGIC CANCER (i.e. CANCER OF THE OVARY, UTERUS, CERVIX, VAGINA)

Who? _____

Age at diagnosis: _____

MENSTRUAL HISTORY

Date of your last menstrual period? _____

Duration of flow: _____ DAYS

Are your periods regular? ☐ Yes ☐ No

How often do your periods come? EVERY _____ DAYS

Age that you started having periods: _____

Age that you started menopause: _____

SEXUAL HISTORY

Are you sexually active? ☐ Yes ☐ No

Are you sexually active with men, women or both? ☐ Men ☐ Women ☐ Both

How many sexual partners have you had in the past year? _____

Any sexual problems? ☐ Yes ☐ No

Have you been hit, kicked, punched or otherwise hurt by someone within the past year? ☐ Yes ☐ No

Do you feel safe in your current relationship? ☐ Yes ☐ No

Is there a partner from a previous relationship who is making you feel unsafe now? ☐ Yes ☐ No

PREGNANCY HISTORY

Have you ever been pregnant? ☐ Yes ☐ No (if no, then you may stop)

Age at first child: _____ Number of miscarriages: _____

Number of pregnancies: _____ Number of abortions: _____

Number of births: _____ Number of living children: _____

Have you ever been diagnosed with gestational diabetes? ☐ Yes ☐ No