CROSS ROADS
Hormonal Health & Wellness

Female Medical History

Name: _____DOB: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American ☐ White ☐ Hispanic or Latino ☐ Unreported/Refused to Report

PATIENT HISTORY QUESTIONNAIRE

Reason for this visit: _____
Referring Physician/How did you hear about us? _____
Occupation: _____
Preferred phone number: _____ Confidential voice mails OK: ☐ Yes ☐ No
Partner: _____ ☐ None Age of partner: _____
Last First Occupation of partner: _____
Marital Status: ☐ Single ☐ Married ☐ Long term relationship ☐ Divorced ☐ Widowed

PAST MEDICAL HISTORY

Check any that apply:

☐ Arthritis ☐ Kidney Disease ☐ Asthma ☐ Gallstones ☐ Emphysema
☐ Liver Disease ☐ Bronchitis ☐ Epilepsy ☐ HIV+ ☐ High blood pressure
☐ Blood Transfusions ☐ Heart disease ☐ Thyroid disease ☐ Diabetes
☐ Controlled diet ☐ Pill controlled ☐ Insulin controlled
☐ Other_____

DRUG ALLERGIES

☐ Yes ☐ No **Reaction:**_____
List: _____

MENSTRUAL HISTORY (complete even if post-menopausal or no longer having periods)

Age at first period: _____ years
If your menstrual periods are regular; periods start every: _____ days
If your menstrual periods are irregular; periods start every: _____ to _____ days (e.g., 12 to 60)
Duration of bleeding: _____ days
Does bleeding or spotting occur between periods? Yes ☐ No ☐
Does bleeding or spotting occur after intercourse? Yes ☐ No ☐
First day of last menstrual period _____/_____/_____
Month / day / year
Is pain associated with periods? Yes ☐ No ☐ Occasionally ☐
If yes, is it: before menses? ☐ during menses? ☐ both? ☐

PAP SMEAR/MAMMOGRAM HISTORY

Date of last pap smear: _____

Have you had abnormal pap smears? ☐ Yes ☐ No

Have you had treatment for abnormal pap smears? ☐ Yes ☐ No

If yes, what type(s) treatment have you had?

☐ cryotherapy ☐ laser ☐ cone biopsy ☐ loop excision (LEEP) _____ YEAR

Date of last mammogram: _____ _____

Have you had an abnormal mammogram? ☐ Yes ☐ No

OTHER PAST GYNECOLOGICAL HISTORY

Check any that apply: ☐ None ☐ Venereal warts ☐ Herpes-genital ☐ Syphilis

☐ Pelvic inflammatory disease ☐ Endometriosis ☐ Chlamydia ☐ Gonorrhea

☐ Vaginal infections ☐ Other_____

PREGNANCY HISTORY (All pregnancies) Never been pregnant ☐

OBSTERTRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

						CHILD		
Date of birth	**Place of delivery or Abortion**	**Duration of Pregnancy**	**Hrs. of Labor**	**Type of Delivery**	**Complications Mother and/or Infant**	**Sex**	**Birth Weight**	**Present Health**
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SEXUAL HISTORY

Do you have a sexual partner? Yes ☐ No ☐ (Male ☐ Female ☐)

Are there concerns about your sexual activity which you may want to discuss with your doctor?

Yes ☐ No ☐

PAST OBSTERTRICAL/GYNECOLOGICAL SURGERIES

Check any that apply:

SURGERY	**YEAR**	**SURGERY**	**YEAR**
☐ D & C	_____	☐ ovarian surgery	_____
☐ Hysteroscopy	_____	☐ L cyst(s) removed ovarian	_____
☐ Infertility surgery	_____	☐ R cyst(s) removed ovarian	_____
☐ Tuboplasty	_____	☐ L ovary removed	_____
☐ Tubal ligation	_____	☐ R ovary removed	_____
☐ Laparoscopy	_____	☐ vaginal or bladder repair	
☐ Hysterectomy (vaginal)	_____	for prolapsed or incontinence	_____
☐ Hysterectomy (abdominal)	_____	☐ cesarean section	_____
☐ Myomectomy	_____	☐ none	_____

☐ other (specify): _____

BIRTH CONTROL HISTORY

What birth control method(s) do you currently use?

_____

PAST SURGICAL HISTORY (Not OB/GYN)

List all surgeries and their year: ☐ None

Surgeries	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

	Relative Affected	Age Diagnosed	Living / Deceased
☐ Diabetes			
☐ Heart Disease			
☐ Breast Cancer			
☐ Ovarian Cancer			
☐ Endometrial Cancer			
☐ Colon Cancer			
☐ Other			

_____

_____

Do you currently?

☐ Smoke ☐ Yes ☐ No _____ packs/day

☐ Use alcohol ☐ Yes ☐ No

____ Wine (glasses/day) ____ beer (bottles/day) ____ hard liquor (oz. /day)

☐ Use illicit drugs ☐ Yes ☐ No _____ type _____ amount

☐ Exercise: Type: _____ How often _____

PATIENT SIGNATURE **DATE**

Email to: smile@crwhealth.com