4239 Farnam St. Suite 734 / (402) 552-2700
16909 Lakeside Hills Ct. Suite 201 / (402) 991-1900
Emergencies & After Hours / (402) 552-2700
Medical Record Fax / (402) 552-2972
Office Fax / (402) 552-2709

FEMALE MEDICAL HISTORY *(Please Complete Before Your Visit)*

Contact Information

Name: _____ Preferred First Name (if different): _____

Phone #: _____ *(cell # may be preferred)* OK to leave a message? _____YES _____NO

Referred by: _____ Preferred Pharmacy: _____

Health Care Providers (✔**CHECK** if you would like a note sent to your health care provider)

__Primary Care: _____ __Counselor/Therapist: _____

__Gynecologist: _____ __Physical Therapist: _____

__Counselor/Therapist: _____ __Psychiatrist: _____

__Other: _____

Demographic Information

Are you (circle all that apply):

Single Married Widowed Committed Relationship Same Sex Relationship

Education:

Less than 12 years High school graduate Currently in school

College Degree Postgraduate degree

What is your profession/what type of work are you doing? _____

Information About Your Condition

What are your primary concerns? _____

_____

How long have you had the issues or concerns? _____

Is there an event associated with the onset of symptoms? ___No ___Yes (explain) _____

_____

What medical/nonmedical treatments have you tried? _____

_____

Medical History

How many pregnancies have you had? _____

Resulting in (#): _____Full 9 months _____Premature _____Miscarriage _____Abortion _____Living children

Age of children: _____

What is your method of birth control? _____ or N/A

Date of last Pap smear: _____ Date of last Mammogram: _____ or N/A

✔**CHECK** all that apply:

_____Heavy menstrual flow	_____Hysterectomy/no uterus	_____Pain with wearing tight pants
_____Menstrual cramps	_____Removal of 1 ovary	_____Pain with tampon insertion
_____Irregular periods	_____Removal of both ovaries	_____Pain with sexual activity
_____Last period > 1 year ago	_____Endometriosis	_____Pain with initial penetration
_____Endometrial ablation	_____Hot flashes	_____Pain with deep penetration
_____Pelvic pain	_____Night sweats	_____Burning vaginal pain after sex
_____Recurrent vaginal infections (yeast or bacterial)	_____Vaginal itching	_____Low/absent sexual desire
_____Abnormal Pap smear	_____Vaginal discharge	_____Difficulty with lubrication
_____HPV	_____Vaginal tears (paper cut tears)	_____Never had an orgasm
_____Genital Herpes	_____Vaginal dryness	_____Delayed ability to orgasm

✔**CHECK** all that apply:

_____Fatigue	_____Constipation	_____Diabetes
_____Weight gain	_____Diarrhea	_____Back pain / Join pain
_____Difficulty sleeping	_____Irritable bowel syndrome	_____Osteoporosis / Osteopenia
_____High blood pressure	_____Burning with urination	_____Migraines
_____High cholesterol	_____Urinary frequency	_____Fibromyalgia
_____Blood clot	_____Frequent UTIs	_____Difficulty focusing
_____Heart attack	_____Interstitial cystitis	_____Irritability
_____Stroke	_____Leakage of urine	_____Attention Deficit Disorder
_____Breast tenderness	_____Facial hair growth	_____Anxiety
_____Breast cancer	_____Scalp hair thinning	_____Depression
Other cancer_____	_____Hypothyroid	_____Bipolar disorder

Other medical conditions: _____

Health History

**How often do you exercise?* Rarely 1-2 Times weekly 3-5 times weekly Daily

**How many cups of caffeine per day?* (include coffee, tea, soda) 0 1-3 4-6 More than 6

**Do you smoke cigarettes?* NO YES *How many cigarettes per day?* _____ *For how many years?* _____

**How often do you drink alcohol?* Never Rarely Monthly Weekly Daily

**Do you use recreational drugs?* NO YES

**How would you describe your diet?* (circle all that apply)

Well- Balanced Fried/Fast food Low Fat Low Cholesterol Other: _____

**Do you have issues/concerns with your body image or eating habits?* NO YES

**Please list any causes of stress* (ex. finances, work, relationship) _____

**Have you ever been the victim of:* Verbal abuse Physical abuse Sexual abuse Rape No Answer

ALLERGIES: _____

Current Medications

Medication	Dose/Frequency	Notes

Surgical Procedures

Year	Procedure	Year	Procedure

Family History

✔Check if you were you adopted ____ (Leave BLANK If you do not know your family history).

✔Check box if a family member has been diagnosed/treated for any of the following:

	Mom	Dad	Brother	Sister	Grandma (mom's parent)	Grandma (dad's parent)	Grandpa (mom's parent)	Grandpa (dad's parent)
Anxiety								
Depression								
Heart Disease								
High Cholesterol								
Stroke								
Breast cancer								
Ovarian cancer								
Prostate cancer								
Uterine cancer								

Additional comments or conditions not listed above: _____

_____