Beach Cities Midwifery and Women's Health Care
Annual Review of Health

Name ______________________________ Age ________ Date ________
Referred by ______________________________
Reason for visit ______________________________
Name of Primary Care Physician ______________________________

Thank you for taking the time to complete this health history form. It will assist the nurse midwife to review your health and provide information regarding health maintenance. If this is a return visit for you please just update the information with any changes within the past year.

Marital Status Are you single? _____ Married? _____ Divorced? ___
Separated? _________ Widowed? ___ Partnered? ___

What is your height? _____________ What is your usual weight? _____________

OBSTETRICAL HISTORY

How many times have you been pregnant? ___________
Number of vaginal births? ______ Cesarean sections? __ Reason? __________
Number of miscarriages? ______ Elective abortions? ________
Number of ectopic pregnancies? _______ Number of premature births? _______
Have you ever had any stillborn babies? _______
Did you have any complications of pregnancy other than those mentioned above? ___
If yes, please explain ______________________________
How many pounds/ounces was your largest infant? ______________________________
How many living children do you have? ______ Adopted children? _________
Do you wish more pregnancies? _____________

GYNECOLOGIC HISTORY

Menstrual Periods

Date of last menstrual period _____________ was it normal? ____________
How frequently do your periods occur? ________ days and last for ________ days
Are you taking birth control pills? _____ Hormone replacement therapy? _____
Any recent changes in your periods? ______, if yes, describe ______________________
____

Do you have

Excessive pain with your periods? Yes ________ No ________
Excessive bleeding with your periods? Yes ________ No ________
Premenstrual symptoms (PMS) Yes ________ No ________
If yes, describe ______________________________
____

PREVENTIVE HEALTH

Do you have annual check ups with a family doctor or internist? Yes _____ No _____
Date of last visit ___________________

Pap Smears

Date of last Pap smear _______________ normal ______ abnormal ________
Have you ever had an abnormal Pap? No ________ If yes, when __________________
Any treatment? ______________________________

Mammogram

Date of last mammogram _______________ normal ______ abnormal _____

Do you do breast self exams? Yes ________ No _________

Have you ever had a breast lump? Yes ________ No _________

Sexuality

Are you sexually active? Yes ________ No _________

Do you have pain with sexual relations? Yes _________ No _________

Are your partner(s) Men? ___ Women? ____ Both ________

Have you ever had a partner who was bisexual or used IV drugs? ______________

How many sex partners have you had since becoming sexually active? _________

Have you ever been physically, sexually or mentally abused by your spouse, partner or other family member? Yes _________ No _________

Have you ever been raped? Yes ________ No _________

Do you have any questions regarding sexuality? Yes _____ No _________

Birth Control

Do you have a need for birth control Yes _________ No_________

Are you using any birth control now? Yes _________ No _________

If yes, what is your current method (circle one)

Pill IUD/IUS Rhythm Condoms Diaphragm

Withdrawal Tubal Sterilization/ Vasectomy Implanon Depo (shot)

Are you satisfied with this method? Yes _________ No _________

What other methods of birth control have you previously used? _______________

Infections

Do you have recurrent vaginal infections? Yes _________ No _________

If yes, what kind ____

Have you ever had a sexually transmitted infection? Yes _________ No ________

Herpes ______ Warts ______ Chlamydia _____ Gonorrhea _________

Syphillis _____ HIV ______ Pelvic Inflammatory Disease ____________

Other ____

Treatment you received ____

Do you have recurrent bladder infections? Yes _________ No _________

What treatment have you received? ________________________________

Menopause

Have you stopped having periods? Yes _________ No _________

Hysterectomy? Yes _________ No _________ When?______

Surgical removal of your ovaries? Yes ____ No ___ When?______

Do you take hormone replacement? Yes _________ No_________

If yes, what medication do you take and how do you take it? ___________

____

Have you had any vaginal bleeding since menopause? Yes___ No___

Do you have: Accidental loss of urine? ____ Vaginal dryness? ____

Pelvic pressure?_____ Hot flashes?________ Pain with sex?______

PAST MEDICAL HISTORY – Please answer the following questions about your health and medical history

Allergies____

Medications you are presently taking (including hormones, over the counter medications, and/or herbal remedies)

1. ____________________________ 2. ____________________________

3. ____________________________ 4. ____________________________

Operations Date Type Where Complications

1. ____________________
2. ____________________
3. ____________________
4. ____________________

Medical Illnesses or Problems

1. ____________ 2. ____________
3. ____________ 4. ____________

Have you had problems with any of the following conditions?

High blood pressure	______	Diabetes	_____	Lung disease	_______
Bladder infections	______	Hepatitis	_____	Heart disease	_______
Thyroid disease	______	Asthma	_____	Migraines	_________
Kidney disease	______	Seizures	_____	Anorexia/Bulemia	___
Blood clots	______	Arthritis	_____	Depression	________
Abnormal hair growth	______	Other	______________		

Have you ever had a blood transfusion? Yes ______ No ______

FAMILY HISTORY

Please identify the age and health status for:

Your mother Age _______ General Health ☐ Excellent ☐ Good ☐ Fair ☐ Deceased

Your father Age _______ General Health ☐ Excellent ☐ Good ☐ Fair ☐ Deceased

Your siblings Age _______ General Health ☐ Excellent ☐ Good ☐ Fair ☐ Deceased

____

Has anyone in your family (blood relative) had any of the following conditions:

High blood pressure	______	Diabetes	_____	Colon cancer	_______
High cholesterol	______	Heart Disease	______	Osteoporosis	_______
Breast/ovarian cancer	______	Birth Defects	_______		

Other conditions______________________

Are you adopted? Yes ______ No ______

SOCIAL HISTORY

1. Do you smoke? _____ How much? ________ How long? _________
   If you quit, how long ago was that? __________________
2. Do you drink alcohol?______ Rarely_______ Occasionally________
   Daily________ Do you regularly have one or more drinks per day? _______
3. Do you use drugs socially? ________ What do you use? _______________
   Have you ever used IV drugs? _____ Have you ever had a test for HIV? __
4. Do you exercise regularly? ________ How many times/week?__________
5. Do you diet?________ What do you do to diet? ____________________________
   ____
6. What is the last grade of school you attended?____________________________
7. What is your occupation?____

Are you having any problems with any of the following:

No	Yes	If yes, please describe
☐	☐	Eyes, ears, nose, throat ____________________
☐	☐	Chest ____________________
☐	☐	Heart ____________________
☐	☐	Abdomen ____________________
☐	☐	Back ____________________
☐	☐	Arms/Legs ____________________
☐	☐	Elimination ____________________
☐	☐	Other ____________________

Do you have any other concerns or questions: ____________________

____

____

____

We appreciate the time and effort you have taken to complete this questionnaire and look forward to working with you for your health care needs.