

PHYSICIANS FOR WOMEN ANNUAL HISTORY FORM

NAME _____ DATE _____

- REASON FOR VISIT: _____
ALLERGIES(drugs, food, materials) _____
CURRENT MEDICATIONS: _____

- CONSTITUTIONAL: [] NO change since ___/___/___ visit
[] weight loss [] weight gain [] fever [] fatigue [] change in height [] allergies _____

- GASTROINTESTINAL: [] NO change since ___/___/___ visit
[] diarrhea [] constipation [] bloody stool [] pain [] nausea/vomiting
[] indigestion [] involuntary loss of gas or stool

- GENITOURINARY: [] NO change since ___/___/___ visit
Age of menses _____, frequency of periods _____, type of birth control _____
[] frequent urination [] blood in urine [] pain with urination [] urgency
[] incontinence [] abnormal or painful periods [] painful intercourse
[] abnormal bleeding from vagina [] abnormal vaginal discharge [] PMS
[] DES exposure [] infertility
Sexual orientation [] heterosexual [] homosexual [] bisexual

- BREAST: [] NO change since ___/___/___ visit LAST MAMMOGRAM _____
[] pain in breast [] nipple discharge [] lumps

- CARDIOVASCULAR: [] NO change since ___/___/___ visit
[] painful breathing [] chest pain or pressure [] difficulty breathing on exertion
[] swelling of legs [] rapid or irregular heartbeat

- ENDOCRINE: [] NO change since ___/___/___ visit
[] hot flashes [] hair loss [] abnormal thirst [] heat/cold intolerance

- PAST MEDICAL/SURICAL HISTORY: [] NO change since ___/___/___ visit
Surgeries _____
Medical Conditions _____
Injuries _____
Immunizations _____

- FAMILY HISTORY: [] NO change since ___/___/___ visit
Mother [] living [] deceased - cause: _____ age _____
Father [] living [] deceased - cause: _____ age _____
Siblings: No. living _____ No. deceased _____ causes/ages _____
Cancer in family _____

- PAST OB HISTORY: Pregnancies _____, Deliveries _____, Vaginal or c/section _____
miscarriages and/or abortions _____
Number living _____ Number deceased _____ causes/ages _____

- SOCIAL HISTORY:
Tobacco use _____ alcohol/drug use _____ seat belts _____ Diet _____
exercise _____ Vitamins/Herbs _____ Caffeine _____