Bright Eyes MIDWIFERY & Wild Rivers WOMEN'S HEALTH CLINIC, LLC
PO Box 1710
Gold Beach, OR 97444
T: 541.425.5311
F: 541.425.5577

PATIENT HEALTH HISTORY

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

DATE OF BIRTH: _____/ _____/_____ HEIGHT: _____ FEET _____ INCHES WEIGHT: _____

OCCUPATION: _____

EDUCATIONAL LEVEL: HS Diploma/GED ____ SOME COLLEGE ____ COLLEGE/GRADUATE DEGREE ____ NONE ____

MARITAL STATUS: SINGLE ____ MARRIED ____ SEPERATED ____ DIVORCED ____ WIDOWED ____ PARTNER ___

NAME OF SIGNIFICANT OTHER: _____

PRIMARY CARE PROVIDER NAME: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE:_____ RELATIONSHIP: _____

REASON FOR TODAY'S VISIT: _____

FAMILY MEDICAL HISTORY

IMPORTANT: PLEASE DO NOT SKIP THIS SECTION. FAMILY HISTORY COULD BE AN IMPORTANT FACTOR IN YOUR FUTURE HEALTH. PLEASE DOCUMENT BELOW IF A FAMILY MEMBER HAS A PAST OR CURRENT MEDICAL PROBLEM. (EX: DIABETES, HEART ISSUES, HIGH CHOLESTEROL, HIGH BLOOD PRESSURE, ETC.)
IF A FAMILY MEMBER IS DECEASED, PLEASE LIST THE CAUSE AND AGE.

MOTHER: _____

FATHER: _____

SISTER(S): _____

BROTHER(S):_____

PATERNAL GRANDMOTHER:_____

PATERNAL GRANDFATHER: _____

PATERNAL AUNTS, UNCLES AND COUSINS: _____

MATERNAL GRANDMOTHER: _____

MATERNAL GRANDFATHER:_____

MATERNAL AUNTS, UNCLES AND COUSINS: _____

PERSONAL MEDICAL HISTORY

PLEASE CHECK ANY OF THE FOLLOWING DISEASES/ILLNESSES YOU HAVE HAD OR CURRENLTLY HAVE:

HEART ATTACK: ____ HEART DISEASE: ____ HEART FAILURE: ____ DATE(S) OF ONSET: _____

DIABETES: TYPE 1: ___ TYPE 2: ___ HIGH BLOOD PRESSURE: ____ DATE(S) OF ONSET: _____

HEARTBURN: _____ STOMACH ULCER: _____ ACID REFLUX: ____ DATE(S) OF ONSET: _____

CANCER: ____ TYPE: _____ DATE(S) OF ONSET: _____

ASTHMA: _____ LUNG DISEASE: _____ TUBERCULOSIS: _____ DATE(S) OF ONSET: _____

HEPATITIS: _____ LIVER DISEASE: _____ KIDNEY DISEASE: _____ DATE(S) OF ONSET: _____

HYPOTHYROIDISM: ____ HYPERTHYROIDISM: ____ DATE(S) OF ONSET: _____

OVARIAN/UTERINE PROBLEM: ____ TYPE: _____ DATE(S) OF ONSET: _____

HERNIA: ____ TYPE: _____ DATE(S) OF ONSET:_____

ANEMIA: ____ TRANSFUSION: ____ BLEEDING TENDANCY: _____ DATE(S) OF ONSET: _____

OTHER:_____ DATE(S) OF ONSET: _____

ALLERGIES

TO MEDICATIONS: Y N TO LATEX, SOAP, TAPE OR FOOD: Y N

LIST ALL ALLERGIES IN WHICH YOU HAVE AN EXPERIENCED REACTION TO AND DESCRIBE THE TYPE OF REACTION

ALLERGEN: REACTION:

_____

_____

_____

SURGICAL HISTORY

PLEASE LIST ALL PAST SURGIES AND OUT-PATIENT PROCEDURES (INCLUDE COLONOSCOPIES)

SURGERY: DATE: PLACE:

_____

_____

_____

_____

_____

_____

OBSTESTRICAL HISTORY

TOTAL NUMBER OF PREGNANCIES: _____ NUMBER OF LIVING CHILDREN: _____

1 – WEEKS OF GESTATION: _____ VAGINAL: _____ CESAREAN: _____ MISCARRIAGE: _____ ABORTION: _____

D.O.B: ____/____/_____ PLACE OF BIRTH: _____ BIRTHWEIGHT: _____ SEX: M F

HOURS OF LABOR: _____ ANESTHESIA? Y N PROBLEMS: _____

2 – WEEKS OF GESTATION: _____ VAGINAL: _____ CESAREAN: _____ MISCARRIAGE: _____ ABORTION: _____

D.O.B: ____/____/_____ PLACE OF BIRTH: _____ BIRTHWEIGHT: _____ SEX: M F

HOURS OF LABOR: _____ ANESTHESIA? Y N PROBLEMS: _____

3 – WEEKS OF GESTATION: _____ VAGINAL: _____ CESAREAN: _____ MISCARRIAGE: _____ ABORTION: _____

D.O.B: ____/____/_____ PLACE OF BIRTH: _____ BIRTHWEIGHT: _____ SEX: M F

HOURS OF LABOR: _____ ANESTHESIA? Y N PROBLEMS: _____

4 – WEEKS OF GESTATION: _____ VAGINAL: _____ CESAREAN: _____ MISCARRIAGE: _____ ABORTION: _____

D.O.B: ____/____/_____ PLACE OF BIRTH: _____ BIRTHWEIGHT: _____ SEX: M F

HOURS OF LABOR: _____ ANESTHESIA? Y N PROBLEMS: _____

5 – WEEKS OF GESTATION: _____ VAGINAL: _____ CESAREAN: _____ MISCARRIAGE: _____ ABORTION: _____

D.O.B: ____/____/_____ PLACE OF BIRTH: _____ BIRTHWEIGHT: _____ SEX: M F

HOURS OF LABOR: _____ ANESTHESIA? Y N PROBLEMS: _____

MENSTRUAL HISTORY

WHAT WAS THE FIRST DAY OF YOUR LAST PERIOD? ____/____/_____

HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST PERIOD? ____

ARE YOUR CYCLES REGULAR? Y N NONE DO YOU HAVE PREMENOPAUSAL SYMPTOMS? Y N

ARE YOUR PERIODS: ___LIGHT ___MODERATE ___HEAVY CRAMPS? ___MLD ___MODERATE ___ HEAVY

PREMESTRUAL PROBLEMS: ___BLOATING ____PAIN ____MOODINESS ____BREAST PAIN ____OTHER

PLEASE LIST OTHER SYPMTOMS:_____

DO YOU HAVE POSTMENOPAUSAL SYMPTOMS? Y N

GYNECOLOGICAL HISTORY

DATE OF LAST PAP SMEAR: ___/___/_____ NORMAL? Y N HAVE YOU EVER HAD AN ABNORMAL PAP? Y N
IF YES, LIST YEAR(S) AND TREATMENT: _____

VAGINAL PROBLEMS? ____DISCHARGE ____ODOR ____ITCHING ____OTHER: _____

DATE OF LAST MAMMOGRAM ____/____/_____ NORMAL? Y N DO YOU DO SELF BREAST EXAMS? Y N

DO YOU HAVE ANY BREAST ISSUES? ____TENDERNESS ____PAIN ____LUMP(S) ____NIPPLE DISCHARGE

DATE OF LAST BONE DENSITY (DEXA) SCAN: ____/____/_____

ARE YOU CURRENTLY IN A RELATIONSHIP? Y N FOR HOW LONG? _____

PROBLEMS: ___ DECREASED SEX DRIVE ____PAIN WITH SEX ____VAGINAL DRYNESS ____BLEEDING AFTER SEX

OTHER: _____

HAVE YOU EVER HAD A SEXUALLY TRANSMITTED INFECTION (STI)? Y N

IF YES, PLEASE LIST: _____

LIFESTYLE

BRIEFLY DESCRIBE YOUR DIET STYLE: _____

HOW MANY SERVINGS OF DAIRY OR OTHER CALICUM RICH FOODS DO YOU EAT ON AN AVERAGE DAY? _____

HOW MANY SERVINGS OF FRUIT? _____ VEGETABLES? _____ WHOLE GRAINS?_____ PROTEINS? _____

WHAT TYPE(S) OF PROTEIN DO YOU EAT? _____

HOW OFTEN DO YOU EXERCISE? _____ HOW LONG DO YOU EXERCISE? _____

WHAT TYPE(S) IF EXERCISE? _____

ARE YOU CURRENTLY IN RECOVERY FOR ALCOHOL OR SUBSTANCE USE? Y N

DO YOU SMOKE CIGARETTES? Y N IF YES, HOW MANY IN A DAY? _____

DO YOU USE RECREATIONAL DRUGS OR PRESCRIPTION MEDICATION FOR NONMEDICAL REASONS? Y N
*****IF YES, PLEASE COMPLETE THE SUPPLEMENTAL DRUG SCREENING QUESTIONNAIRE*****

(LIFESTYLE CONT.)

HOW OFTEN DO YOU HAVE A DRINK CONTAINING ALCOHOL?
NEVER (0 POINTS) ____
MONTHLY OR LESS (1 POINT) ____
2-4 TIMES A MONTH (2 POINTS) ____
2-3 TIMES A WEEK (3 POINTS) _____
4+ TIMES A WEEK (4 POINTS) _____

HOW MANY STANDARD DRINKS CONTAINING ALCOHOL DO YOU HAVE ON A TYPICAL DAY?
0-1 (0 POINTS) ____
1-3 (1 POINT) ____
4-6 (2 POINTS) ____
7-9 (3 POINTS) ____
10+ (4 POINTS) ____

HOW OFTEN DO YOU HAVE SIX OR MORE DRINKS ON ONE OCCASION?
NEVER (0 POINTS) ____
LESS THAN MONTHLY (1 POINT) ____
MONTHLY (2 POINTS) ____
WEEKLY (3 POINTS) ____
DAILY OR ALMOST DAILY (4 POINTS) ____

TOTAL NUMBER OF POINTS FROM PREVIOUS 3 QUESTIONS: _____
*****IF SCORE IS 3 OR MORE, PLEASE COMPLETE SUPPLEMENTAL ALCOHOL SCREENING QUESTIONNAIRE*****

EMOTIONAL HEALTH

DURING THE PAST FOUR WEEKS HAVE YOU:

BEEN BOTHERED BY LITTLE INTEREST OR PLEASURE IN DOING THINGS? Y N
BEEN BOTHERED BY FEELING DOWN, DEPRESSED OR HOPELESS? Y N
BLAMED YOURSELF UNNECESSARILY WHEN THINGS WENT WRONG? Y N
BEEN ANXIOUS OR WORRIED FOR NO GOOD REASON? Y N
FELT SCARED OR PANICKY FOR NO GOOD REASON? Y N

ARE YOU CURRENTLY OR HAVE YOU EVER BEEN IN A RELATIONSHIP WHERE YOU WERE PHYSICALLY HURT, CHOKED, THREATENED, CONTROLLED OR MADE TO FEEL AFRAID? Y N

*****IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE COMPLETE THE SUPPLEMENTAL DEPRESSION INVENTORY*****

REVIEW OF BODY SYSTEMS

IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS LISTED, PLEASE CHECK THEM.

GENERAL:

___WEAKNESS ___FATIGUE ___CHILLS ___ FEVER ___NIGHT SWEATS ___APPETITE CHANGE ___WEIGHT CHANGE

SKIN:

___COLOR CHANGE ___RASH ___ITCHING ___CHANGE IN MOLES ___CHANGE IN HAIR ___CHANGE IN NAILS

HEMATOPOIC (PROBLEMS WITH):

____ANEMIA ____ABNORMAL BLEEDING ____EXCESSIVE BRUISING ____LYMPH NODE ENLARGEMENT

HEAD, EYES, EARS, NOSE OR THROAT:

PROBLEMS WITH VISION OR HEARING? _____

RESPIRATORY:

____ COUGH ____ CONGESTION ____ WHEEZING ____SHORTNSS OF BREATH ____DIFFICULTY BREATHING

CARDIOVASCULAR:

____ CHEAST PAIN ____ CHEST PAIN ON EXERTION ____EDEMA /FLUID RETENTION

GASTROINTESTINAL:

___DIFFICULTY SWALLOWING ___ NAUSEA ___ VOMITING ___CONSTIPATION ___DIARRHEA ___BLOOD IN STOOL

MUSCULOSKELETAL:

___JOINT PAIN ___SWELLING ___ STIFFNESS ___ ARTHRITIS

ENDOCRINE (GLANDS):

___ HEAT INTOLERANCE ____COLD INTOLERANCE

URINARY TRACT:

___ URINARY FREQUENCY ___ FREQUENT URGES TO GO ___ LEAKING OF URINE ___ PAIN IN URINATION

NEUROLOGIC:

____EXCESSIVE HEADACHES ___MIGRAINES ___DIZZINESS ___FAINTING

PSYCHIATRIC:

___ANXIETY ___ DEPRESSION ___ MOODSWINGS