Inanna Birth & Women's Care
940-483-1569

Name _____ DOB _____

Patient History

FAMILY

If living (L), indicate state of health, if deceased (D), indicate cause of death.

Please indicate if there is a family history of Diabetes, Heart Disease, High Blood Pressure or Birth Defects, identifying whom.

Father (age ___) _____ (L) _____ (D) _____
Mother (age ___) _____ (L) _____ (D) _____
Sibling (M F) (age ___) _____ (L) _____ (D) _____
Sibling (M F) (age ___) _____ (L) _____ (D) _____
Sibling (M F) (age ___) _____ (L) _____ (D) _____
Sibling (M F) (age ___) _____ (L) _____ (D) _____

☐ **No significant familial diseases, heritage disorders, birth defects, mental retardation or pregnancy loss**
☐ **Otherwise see notes:**

MEDICAL / SURGICAL

Have you ever had:

☐ Severe Headaches	☐ Hemorrhage	☐ Colitis	☐ Bone Disease
☐ Eye/Vision Problems	☐ Varicose Veins	☐ Blood in Stool	☐ Cancer
☐ Ear/Hearing Problems	☐ Hemorrhoids	☐ Gall Bladder Problems	☐ Mental Health Problems
☐ Dental Problems	☐ Immune Disorder	☐ Liver Problems	☐ Seizures
☐ Thyroid Problems	☐ Tuberculosis	☐ Hepatitis	☐ Serious injury
☐ Heart Disease	☐ Asthma/Breathing	☐ Diabetes	☐ Childhood health Problems
☐ Muscle Disease	☐ Stomach Problems	☐ Hypoglycemia	☐ Other _____
☐ High Blood Pressure	☐ Ulcers	☐ Blood transfusion	☐ None
☐ Blood Clotting Problem	☐ Kidney/bladder Prob.	☐ Aching Joint/Arthritis	
☐ Anemia	☐ Bowel Problems	☐ Pelvic/Back injury	

Vitamins / Herbs / Supplements / Medications / Other

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SOCIAL

Y N Do you smoke? If so, how much? _____
Y N Do you exercise regularly?
Y N Do you use alcohol? If so, how often? _____
Y N Have you ever used any street drugs intravenously (IV) or had a blood transfusion?
Y N Have you ever had a sexual partner who used any drug IV, had a blood transfusion or had bisexual relations?
Y N Have you had more than 5 sexual partners in the past 5 years?
Y N Do you think that you are at increased risk for hepatitis, AIDS / HIV?
Y N Have you ever had anorexia, bulimia, eating disorder or unexplained weight changes?
Y N Have you ever been under the care of a therapist / psychiatrist?
Y N Is there anything about your sex life that you would like to discuss?
Y N Do you feel the need to discuss with me privately, a history of an abusive relationship, including current or past abuse (including physical abuse, emotional intimidation or having been beaten, injured or made to take part in sexual activities against your will)?
Y N Have you been treated for anxiety or depression in the past?

GYN

Age at first period _____ Period every _____ days(e.g. 28 days) For _____ days
Flow: Light med heavy First day of last period _____
When was your last pap smear? _____ Mammogram _____n/a Normal? Y N
Y N Have you ever had an abnormal Pap smear? _____ When? _____
If so, what was the method of treatment? _____
Y N Do you have pain with your periods?
Y N Do you have bleeding in between periods?
Y N Do you have any pre-menstrual symptoms?
Y N Do you have symptoms of menopause?
Y N Are you sexually active? Is your partner male of female?_____
Y N Do you have bleeding with intercourse?
Y N Do you have sexual difficulty / discomfort in your relationship? (e.g. decreased desire)
Y N Do you want to discuss birth control?
Last method of birth control _____ Did you like it? Y N
If no, why not? _____
Indicate if you have ever had any of the following:

☐ Yeast	☐ Syphilis	☐ Condyloma (warts)	☐ Breast lumps
☐ Trichomonas	☐ PID	☐ Cervicitis	☐ Abnormal bleeding
☐ HIV / AIDS	☐ Genital sores	☐ Cervical polyp	☐ Infertility
☐ Bacterial vaginosis	☐ Genital Herpes	☐ Ovarian cyst	☐ Other
☐ Chlamydia	☐ Oral Herpes	☐ Fibroids	
☐ Gonorrhea	☐ None	☐ Endometriosis	