SHENANDOAH COMMUNITY HEALTH

Women's Health Information

Name: _____ Date of Birth:_____

What type of work do you do?_____

When was your last immunization for:
Tetanus_____/_____/_____ Pneumonia_____/_____/_____ Influenza (Flu) _____/_____/_____

Have you ever been sexually active? Yes / No
Are you currently sexually active? Yes / No
Age first pregnancy:_____
Current birth control method:_____
Any problems? _____
Date of your last mammogram _____/_____/_____

First day of Last Menstrual Period_____/_____/_____
Date of your last Pap Test____/____/____
Normal? Yes / No
Have you had a hysterectomy? Yes / No
Are you Pre/Post Menopausal? Yes / No
Date of your last colonoscopy _____/_____/____

PREGNANCY HISTORY

Please include miscarriage/abortions	1st pregnancy	2nd pregnancy	3rd pregnancy	4th pregnancy	5th pregnancy	6th pregnancy
Month/Year Delivered						
Weeks gestation (40 is due date)						
Male or Female						
Baby's weight						
Vaginal or cesarean delivery						
Where (town or hospital name)						
Complications						

Are you exposed to physical or emotional abuse? Yes / No
Are you exposed to any domestic violence? Yes / No
Do you need assistance with walking? Yes / No
Do you wear glasses/contact lenses? Yes / No
Do you wear hearing aids? Yes / No
Do you need assistance reading? Yes / No
Do you need assistance writing? Yes / No
Did someone help you complete this form? Yes / No
Do you have any cultural/religious beliefs that effect your care? Yes / No
What is your preferred learning method? *(Please circle one)*
Audio Materials / Demonstration / Verbal Explanation / Video Material / Written Material
Do you have Advanced Directives completed? Yes / No
Do you have smoke detectors in your home? Yes / No
Do you have any guns in your house? Yes / No

What medications do you take? Include prescription, over-the-counter, and herbal supplements:

_____
_____
_____
_____

Over →

Name: _____ Date of Birth:_____

Are you allergic to any medications, anesthetics, iodine, latex, tape, or foods, anything else? Yes / No

_____

_____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Have you ever been hospitalized overnight? Yes / No When and for what reason?_____
Have you ever had surgery? Yes / No When and for what reason?_____

Do you have any current or past medical conditions such as: *(Please circle)*

Headaches
Back Trouble
Ulcers
Trouble swallowing
Arthritis
Anemia
Heart Trouble (Chest Pain, Irregular Heartbeat)
Hepatitis
Stroke
High Blood Pressure
Broken Bones
Asthma
Emphysema
Diabetes
Pneumonia
Tuberculosis
Drug or Alcohol Addiction
Heartburn
Hearing difficulty
HIV
Bowel Trouble
Diarrhea
Infertility
Constipation
Urinary Problems (Infection, Loss of Bladder Control)
Breast Problems
Cancer
Thyroid Problems
Sexual Problems
Back Trouble
Seizures
Mental Health Issues (Depression, Anxiety, Stress)
Vision problems (Blurry Vision, Glaucoma, Cataracts)
Other:_____
_____

Does anyone in your family (children, parents, and siblings) have a history of: (If so, please state who)

Asthma/COPD_____ High Blood Pressure_____
Cancer_____ Mental Health Issues_____
Diabetes_____Stroke_____
Drug/Alcohol Addiction_____ Thyroid Issue_____
Heart Issues_____
Other:_____
Do you smoke or use tobacco? Yes/No How much per day?_____
Do you live with someone who smokes? Yes / No
Do you vape? Yes / No How much per day?_____
How much alcohol do you drink per day?_____
How much caffeine do you drink per day?_____
Do you use marijuana or other drugs? Yes / No Which drugs? _____