VANDERBILT UNIVERSITY
MEDICAL CENTER

NAME:
DOB: / /
DATE: / /
MRN:

Primary Care for Women

Vanderbilt School of Nursing Faculty Practice

Patient Health History

Name ____ Race/Ethnicity: ______________________________

Phone number: ________________________ Email address: ______________________________________

Medication allergies: ____

Other allergies: ____

Current medications (include non-prescription medications, supplements, vitamins, and birth control):

____

How did you hear about our practice?

____

Social History

Relationship status: ☐ single ☐ married ☐ divorced/separated ☐ widowed ☐ partnered ☐ other

Who lives with you? ____

Occupation/Employer ____

What is the highest level of education you have completed? ____

Did you have any special educational needs while in school? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how much? ________ Are you interested in quitting? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No If yes, when did you start and stop (month/year)? __________________

Do you drink alcohol? ☐ Yes ☐ No If yes, how much and how often? ______________________________

Do you drink caffeine? (coffee, tea, soda) ☐ Yes ☐ No If yes, how much and how often? _________________

Do you currently use any recreational drugs? ☐ Yes ☐ No If yes, what drugs? _________________________

Have you used recreational drugs in the past? ☐ Yes ☐ No If yes, what drugs? _________________________

Health Maintenance

Do you regularly exercise? ☐ Yes ☐ No If yes, how often? ________ Type of exercise? __________________

Do you follow a special diet? ☐ No ☐ Vegetarian ☐ Vegan ☐ Other ______________________________

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Do you have: ☐ unexplained weight loss or gain? ☐ weight concerns? ☐ current/past eating disorder?

Immunizations (check if current/immune) ☐ Tetanus/pertussis ☐ Chicken pox ☐ Rubella ☐ Influenza

Do you have an advanced directive/ living will? ☐ Yes ☐ No Would you like information about this? ☐ Yes ☐ No

Do you wear a seat belt? ☐ Yes ☐ No Do you use sunscreen? ☐ Yes ☐ No

Women's Health History

1st day of last menstrual period: ______________, or ☐ post-menopausal ☐ post-hysterectomy
☐ hormonal suppression (= no menses due to breastfeeding, birth control pills, Depo-Provera, IUD, etc.)

Age at first menstrual period: _______ Frequency: every _________ days Periods are: ☐ regular ☐ irregular

Discomfort: ☐ None ☐ minimum ☐ moderate ☐ severe Recent changes? Please describe: ________________

Number of: Total pregnancies? _______ Pregnancy losses/ terminations? ________ Living children? ___________

Are you currently sexually active? ☐ Yes ☐ No If yes, ☐ with men ☐ with women ☐ with both

Lifetime # of sexual partners: ☐ Fewer than 5 ☐ 5 or more

Do you desire STI testing today? ☐ Yes ☐ No

Have you ever been treated for an STI? ☐ Yes ☐ No If yes, which? _________________ When? __________

When was your last Pap smear? _________________

Do you have history of abnormal Pap smears? ☐ Yes ☐ No If yes, when?___________ Treatment? ___________

When was your last: Mammogram? ___________ Colonoscopy? _____________ Bone density scan? ___________

Do you have questions or concerns today about sexual health (i.e. difficulty with orgasm, pain during sex)?
☐ Yes ☐ No If yes, please describe: ____

Because abuse is an enormous problem among women, we ask all of our patients about a history of or present abuse so we may best meet your needs as your care provider.

Have you ever experienced violence or abuse? ☐ Yes ☐ No ☐ I'm not sure. ☐ I prefer not to answer.

If yes, please check all that apply: ☐ Emotional ☐ Physical ☐ Sexual ☐ Verbal ☐ Spiritual ☐ Other: __________

☐ I would like to discuss this in more detail with my midwife. ☐ I do not wish to talk about this during my visit today.

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Personal Medical History

Please check the boxes below as they apply.

- ☐ Abnormal pap
- ☐ Anemia
- ☐ Autoimmune disease
- ☐ Cancer (type: __________________)
- ☐ Congestive heart failure
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Fibroids
- ☐ Gestational Diabetes
- ☐ Headache – Migraine
- ☐ Hepatitis
- ☐ HPV infection
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Glucose intolerance
- ☐ Infertility
- ☐ Kidney stones or disease
- ☐ Lupus
- ☐ Ovarian cancer
- ☐ Pelvic Inflammatory Disease
- ☐ Polycystic ovary syndrome
- ☐ Pulmonary embolism
- ☐ Recurrent miscarriages
- ☐ Seizures
- ☐ Sickle cell anemia
- ☐ STD/STI
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Trauma / Violence
- ☐ Tuberculosis
- ☐ Varicella
- ☐ Other ________________________

Please list past surgeries or hospitalizations and date. ____

____

Family Medical History

Please check the boxes below as they apply. Indicate family member(s) with this history on the line that follows.

- ☐ Bipolar disorder ____________________
- ☐ Cancer (type: __________________) ____________________
- ☐ Crohn's disease ____________________
- ☐ Celiac disease ____________________
- ☐ Dementia ____________________
- ☐ Depression ____________________
- ☐ Diabetes ____________________
- ☐ Heart disease ____________________
- ☐ Hypo/hyperthyroidism ____________________
- ☐ Hypertension ____________________
- ☐ Parkinson's disease ____________________
- ☐ Kidney disease ____________________
- ☐ Schizophrenia ____________________
- ☐ Stroke ____________________
- ☐ Sickle cell disease ____________________
- ☐ Other ____________________

Do you have a family history of breast, colon, or uterine cancer?

(over)

Relationship ______________________________ Age at diagnosis _______________

Do you have a family history of heart attacks or stroke before the age of 55?

Relationship ______________________________ Age at diagnosis ________________

Please circle any symptoms you *currently* have if severe or particularly troublesome:

GENERAL
Unexplained weight loss/ gain
Chills
Fever
Excessive fatigue
Excessive thirst
Allergies

EYE, EAR, NOSE, & THROAT
Ear pain or discharge
Facial swelling
Hearing changes
Mouth sores
Sinus pain
Swollen glands
Sore throat
Tinnitus
Difficulty swallowing
Vision changes
Eye discharge
Eye itching

LUNGS
Difficulty breathing
Bad cough
Coughing up blood
Wheezing

HEART
Chest pain
Irregular heart beat
Murmur
Leg swelling

GASTROINTESTINAL
Abdominal pain
Rectal bleeding
Constipation
Diarrhea
Nausea
Vomiting
Loss of appetite
Frequent heartburn

GENITOURINARY
Pain with urination
Passing blood
Kidney stones
Urgency
Pelvic pain
Sexual function problems
Vaginal discharge

SKELETAL
Joint pain or swelling
Gout
Muscle weakness

SKIN
Skin/hair changes
New/changing moles

NEUROLOGICAL
Dizziness
Severe headaches
Numbness or tingling
Seizures
Tremors

PSYCHIATRIC
Feeling "blue"
Crying spells
Nervous/anxious
Suicidal thoughts
Desire psychiatric help/counseling

Is there anything else we should know about you to help care for you better?

____

This form has been completed to the best of my knowledge. I have reviewed this information with my care provider.

Patient's Signature: ____ Date: _________________________

I have reviewed this information with my patient.

Provider's Signature: ____ Date: _________________________