

1. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

2. Patient Number \_\_\_\_\_ — H

3. Date of Birth \_\_\_\_\_  
 Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

4. Home Address \_\_\_\_\_

5. Age: \_\_\_\_\_ 6. Marital Status: \_\_\_\_\_

7. County of Residence \_\_\_\_\_

8. Race 1.  White 2.  Black 3.  Am. Ind. Ethnicity: Hispanic Origin?  
 4.  Asian 5.  Native Hawaiian/Other Pacific Islander 1.  Yes 2.  No  
 6.  Other

**CONFIDENTIAL**

North Carolina Department of Health and Human Services  
 Division of Public Health  
 Women's and Children's Health Section

**FEMALE SELF-HISTORY FORM**

*If you are unsure about any question, leave it blank and ask the nurse for help.*

**A. IMPORTANT INFORMATION (Please complete the following)**

1. What is the reason for your visit today? \_\_\_\_\_

2. Do you feel that you are in good health?  Yes  No

3. Emergency contact: \_\_\_\_\_

4. May we contact you by mail?  Yes  No by phone?  Yes  No Your phone # is \_\_\_\_\_

5. Are you seeing another doctor for any reason?  Yes  No

6. Do you have any allergies?  Yes  No If yes, what \_\_\_\_\_

7. Highest grade completed in school \_\_\_\_\_

8. Occupation \_\_\_\_\_

**B. List Significant Illness, Hospitalizations, Operations, Accidents and Physical Trauma:**

**C. SELF & FAMILY MEDICAL HISTORY (Please put an X under YOU if you've had any of the following. Put an X under FAMILY if either a parent, grandparent, brother, sister or child of yours has had any of the following)**

YOU / FAMILY	YOU / FAMILY
1. <input type="checkbox"/> Abuse (physical, sexual, verbal, or emotional)	17. <input type="checkbox"/> Hernia
2. <input type="checkbox"/> Anemia, Sickle Cell Disease or Trait, Blood disorder	18. <input type="checkbox"/> High cholesterol, High blood pressure, Stroke
3. <input type="checkbox"/> Anorexia, Bulimia, other eating disorders	19. <input type="checkbox"/> HIV, AIDS
4. <input type="checkbox"/> Arthritis, joint problems, back problems	20. <input type="checkbox"/> Kidney or bladder problems, stones, dialysis
5. <input type="checkbox"/> Asthma, Bronchitis, other breathing problems	21. <input type="checkbox"/> Migraine or severe headaches
6. <input type="checkbox"/> Birth defects, genetic problems, Cystic Fibrosis	22. <input type="checkbox"/> Pain, numbness, broken veins or infection in arms or legs
7. <input type="checkbox"/> Bleeding problems, blood clots in legs or lung, etc.	23. <input type="checkbox"/> Physical disability
8. <input type="checkbox"/> Bowel problems	24. <input type="checkbox"/> Tuberculosis (TB)
9. <input type="checkbox"/> Breast lumps, discharge, tenderness, other problems	25. <input type="checkbox"/> Rectal pain or bleeding, hemorrhoids or "piles"
10. <input type="checkbox"/> Cancers, tumors (including cervical or uterine)	26. <input type="checkbox"/> Female Problems
11. <input type="checkbox"/> Depression, anxiety, mental illness	27. <input type="checkbox"/> Seizures ("fits")
12. <input type="checkbox"/> Diabetes (sugar problems), Gestational Diabetes	28. <input type="checkbox"/> Stomach pain, cramps, ulcers
13. <input type="checkbox"/> Eye problems, blurred vision or spots	29. <input type="checkbox"/> Thoughts of harming self or others
14. <input type="checkbox"/> Fainting, dizzy spells	30. <input type="checkbox"/> Thyroid problems
15. <input type="checkbox"/> Heart disease, heart problems, chest pain, Rheumatic Fever	31. <input type="checkbox"/> Transfusions of blood or blood products
16. <input type="checkbox"/> Hepatitis, liver problems, gallbladder problems	32. <input type="checkbox"/> Twins, Triplets or more

**Provider/Nurse Comments ONLY:**

**D. Infectious Diseases (Please put an (X) by all that you have had)**

1.  Measles 2.  Chicken Pox 3.  Mumps 4.  Any Sexually Transmitted Diseases  
 5.  Rubella 6.  Hepatitis A or B 7.  Tetanus 11.  Other: \_\_\_\_\_  
 8.  Scarlet Fever 9.  Whooping Cough 10.  Meningitis

**E. Vaccine History - May use NCIR print out**

	Date	Vaccine	Date	Other Vaccines	Date
Tetanus shot (Td/Tdap)	_____	Chicken Pox	_____	Influenza (Flu)	_____
Measles shot (MMR)	_____	HPV	_____	Twinrix	_____
Pneumonia	_____	Hepatitis B series	_____	other	_____

**F. Do You:**

- 1. Smoke or use smokeless tobacco  Yes  No If yes, how much? \_\_\_\_\_ How long? \_\_\_\_\_
- 2. Drink alcohol  Yes  No If yes, how much? \_\_\_\_\_ How long? \_\_\_\_\_
- 3. Take street drugs  Yes  No If yes, what? \_\_\_\_\_ How long? \_\_\_\_\_
- 4. Take vitamins with folic acid  Yes  No
- 5. Take diet or herbal supplements  Yes  No If yes, what? \_\_\_\_\_
- 6. Take any medications (prescription or over the counter)  Yes  No If yes, what? \_\_\_\_\_
- 7. Have any dental problems?  Yes  No If yes, what? \_\_\_\_\_

**G. APPETITE/DIETARY/EXERCISE/SAFETY INFORMATION**

- 1. Eat 5 fruits and vegetables a day?  Yes  No
- 2. Eat fewer than 2 meals a day?  Yes  No
- 3. Have trouble getting food?  Yes  No
- 4. Want to eat non-food items like dirt, clay, starch?  Yes  No
- 5. Exercise regularly (walk, swim, bike or other activity 30 minutes 3X/week)?  Yes  No
- 6. Have contact with chemicals/other hazards?  Yes  No
- 7. Use seatbelt while driving/riding in car?  Yes  No
- 8. Notice a weight change of more than 10 lbs?  Yes  No
- 9. Live in a safe place?  Yes  No
- 10. Have smoke detectors at home?  Yes  No
- 11. Have exposure to second hand smoke?  Yes  No
- 12. Have problems with transportation?  Yes  No

**H. SEXUAL & CONTRACEPTIVE HISTORY**

- 1. Age at first intercourse? \_\_\_\_\_
- 2. Date of last intercourse? \_\_\_\_\_
- 3. Are you feeling pressured to have sex?  Yes  No
- 4. Number of partners in past 6 months? \_\_\_\_\_
- 5. How many sexual partners have you had? \_\_\_\_\_
- 6. Do you use condoms every time you have sex?  Yes  No
- 7. Do you have sex with:  Men only  Women only  Both men and women
- 8. Does your partner have sex with:  Men only  Women only  Both men and women
- 9. Do you have pain or bleeding with sex?  Yes  No
- 10. Do you or your partner inject any drugs?  Yes  No
- 11. Have you had an HIV test?  Yes  No  
If yes, when? \_\_\_\_\_
- 12. Has your partner had an HIV test?  Yes  No  
If yes, when? \_\_\_\_\_
- 13. Do you want HIV testing today?  Yes  No
- 14. Does your partner have sex with more than one person?  Yes  No
- 15. Check the ways you have sex:  vaginal  oral  anal
- 16. Have you had recent chills or fever?  Yes  No
- 17. Have you or your partner ever had a sexually transmitted disease (Gonorrhea, Chlamydia, Syphilis, Herpes, Hep B, other)?  Yes  No  
(If yes, please circle which sexually transmitted disease)
- 18. What have you used for birth control in the past?  
 Pills  Depo Shots  Foam/Gel  Diaphragm  IUD  
 Condoms  Withdrawal (Pull out)  Abstain  Other  None
- 19. What are you using now? \_\_\_\_\_
- 20. Are you satisfied with method?  Yes  No
- 21. If no, what method do you wish? \_\_\_\_\_
- 22. Do you or your partner want to become pregnant?  Yes  No  
If yes, when? \_\_\_\_\_

**I. MENSTRUAL/GYNECOLOGICAL HISTORY**

- 1. What age did your menstrual periods begin? \_\_\_\_\_
- 2. When did your last period start? \_\_\_\_\_
- 3. How many days did it last? \_\_\_\_\_
- 4. Was it normal?  Yes  No
- 5. How often do you have your periods? \_\_\_\_\_
- 6. Any problems? \_\_\_\_\_
- 7. Do you douche?  Yes  No
- 8. Do you have a vaginal discharge or odor?  Yes  No
- 9. Do you examine your breasts?  Yes  No  
If yes, how often? \_\_\_\_\_
- 10. Have you ever had a pelvic exam?  Yes  No  
If yes, date of last pelvic exam \_\_\_\_\_
- 11. Date of your last Pap smear \_\_\_\_\_
- 12. Have you ever had an abnormal Pap?  Yes  No  
If yes, what was done \_\_\_\_\_
- 13. Have you ever had a mammogram?  Yes  No

**J. OBSTETRICAL HISTORY**

- 1. If you were born before 1971 did your mother take DES when she was pregnant?  Yes  No  N/A
- 2. Have you ever been pregnant?  Yes  No  
If yes, how many times? \_\_\_\_\_
- 3. How many were:  
Full term? \_\_\_\_ Premature? \_\_\_\_ Stillborn? \_\_\_\_
- 4. How many times did you have:  
A miscarriage? \_\_\_\_ An abortion? \_\_\_\_
- 5. Did any babies weigh less than 5½ lbs. at birth?  Yes  No
- 6. Did any babies weigh more than 9 lbs at birth?  Yes  No
- 7. Are you breast feeding now?  Yes  No
- 8. Did you have a positive Group B Strep test with a previous pregnancy?  Yes  No
- 9. Did you have any problems with any pregnancies?  Yes  No

**Provider/Nurse Comments ONLY:**

[Blank area for provider/nurse comments]

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Interpreter (if used): \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_

(Nurse's signature)

(Date)

(Provider's signature)

(Date)