Prairie Clinic
112 Helen Street Sauk City, WI 53583
www.prairieclinic.com 608-643-3351

FEMALE HISTORY FORM

(Please take a few minutes to fill out this form. It, like all of your medical records, is confidential).

NAME: _____ **DOB:** _____ **DATE:** _____

I am at the clinic for:

List all previous surgeries and dates:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Any problems with (check all that apply):

Diabetes _____ Blood pressure _____ Heart disease _____ Asthma _____
Cancer _____ High cholesterol _____ Thyroid disease _____ Anemia _____

List current and previous medical problems (other than above):

List previous serious injuries (broken bones, trauma, accidents):

Have you ever had a blood transfusion? No Yes When? _____

Current medications with dosage (include over-the-counter drugs, vitamins, herbs, etc.):

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Have you ever used Vioxx, Celebrex or Bextra? No Yes (circle)
Have you ever used fenfluramine (pondimin) or dexfenfluramine (Redux) – "Fen-Phen?" No Yes
Allergies to medications?
No ___
Yes ___ What medicine? _____ Type of reaction: _____
Year of most recent: flu vaccine _____ tetanus vaccine _____ pneumonia vaccine _____

Pregnancies (dates, type of delivery, miscarriage, abortion): _____
Age at first period: _____ First day of last period: _____
Are periods regular? Yes No Cramps with period? Yes No
Last Pap smear: _____ Have you ever had an abnormal Pap result? Yes No
Do you perform self-breast exams? Yes No Last mammogram: _____
Age at menopause: _____ Any bleeding since menopause? Yes No

Have you ever been hit, kicked, punched, or otherwise hurt by someone within the past year? Yes No
If so, by whom? _____
Do you feel safe in your current relationship? Yes No
Is there a partner from a previous relationship who is making you feel unsafe now? Yes No

Do you have a healthcare power of attorney? Yes No
Do you have a living will? Yes No

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Do you see other types of health practitioners? (Chiropractor, acupuncturist, etc.) Yes No
If yes, for what reason? _____

FAMILY HISTORY

Mother: Living/Deceased Age: _____ Health Problems?_____
Father: Living/Deceased Age: _____ Health Problems?_____
Sisters/Brothers: Ages & Health Problems: _____

Please state who in your family has/had the following health problems:

Cancer (breast, colon, prostate, female, other): _____
High blood pressure: _____
High cholesterol: _____
Diabetes: _____
Other health problems: _____

OCCUPATION: _____

SOCIAL HISTORY Married ____ Partnered ____ Single ____ Widowed ____ Divorced ____
If married or in a long-term relationship, list age and occupation of partner:
_____
Children (how old?): _____

HEALTH HABITS (How much and how long):

Tobacco (smoke/chew): No Yes_____
Alcohol: No Yes _____
Have you tried to cut down in the past? No Yes
Coffee/Cola: No Yes_____
Exercise: No Yes _____
Dental: Date of last exam: _____ Any problems? _____
Vision: Date of last exam: _____ Any problems? _____

NUTRITION

How many servings of fruits and vegetables do you eat each day? _____ per day
Do you drink milk or eat yogurt? No Yes If yes, how many servings per day? _____ per day

Have you had significant problems with any of the following? (Please circle those that apply)

Weight loss/gain	Fevers, chills, sweats	Stroke	Anemia
Dizziness	Headaches	Trouble sleeping	Skin or hair changes
Tooth/gum problems	Depression	Anxiety	Loss of energy
Personal problems	Shortness of breath	Glaucoma	Cataracts
Coughing up blood	Problems swallowing	Pneumonia	Cough
Ankle swelling	Waking up out of breath	Hoarseness	Chest pain
Liver disease	Blood clot to lung/leg	Palpitations	Allergies
Heartburn/ulcer	Nausea or vomiting	Diarrhea	Gallbladder
Change in bowels	Blood in stool or urine	Constipation	Seizures
Difficulty with urination	Urinary tract infection	Black stools	Arthritis
Painful urination	Kidney disease/stone	Weakness	Vision loss
Female problems	Painful joints	Double vision	Blurred vision
Heart murmur			

Is there anything else? _____

Thank you for taking the time to fill out this information.