

Women's Form

Family Planning Clinic of Portsmouth, Ohio

605 Washington St. Portsmouth, Ohio

(740) 353-8863

Patient Name

Patient Number

Date of Birth

Date _____ / Age _____

A Pap smear tests for cervical cancer and is only one part of a pelvic Exam. It is done with every pelvic exam. When was your last Pap smear done? _____

- Yes No
- Receiving medical care with another health provider?
List: _____
- Allergic to any medications, metals, products, anesthesia
List: _____
- Current medications (including herbal remedies/vitamins)
List: _____
- Past surgeries/hospital stays (except childbirth/C-section)
List: _____

Family History

- Yes No
- Are you adopted?
- Did your mother take DES when she was pregnant with you (if you were born before 1971)?

Does/did your Mother(M), Father(F), Sister(S), Brother(B) have any of the following?

- | Yes | No | Who? |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Increased Cholesterol _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes/"sugar" _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased Blood Pressure _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | F or B: Heart Attack/Stroke before age 55 _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | M or S: Heart Attack/Stroke before age 55 _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer _____
(Type of Cancer _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do (or did) your grandparents have cancer?
(Type of Cancer _____) |

Menstrual History

Age when period started: _____

Periods are: Regular Irregular Painful
Flow is: Light Normal Heavy

Periods come every _____ days. Bleeding lasts _____ days.

When was the 1st day of your last period _____

Was it normal _____

Problem with periods:

Have you had the following: Don't know

- | | | |
|--------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> HPV/Warts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Scabies |
| <input type="checkbox"/> Trichomonas | <input type="checkbox"/> PID | <input type="checkbox"/> Molluscum |

Dates treated: _____

ROS

Please answer the following (past or present)

- | | Yes | No |
|-----|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> Generally healthy |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> Recent weight gain or loss |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> Frequent cold, flu, etc. |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> Chronic fatigue (>6 months) |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> Cancer |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> Genetic condition |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> Vaccine for Rubella/MMR |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> Vaccine for Tetanus |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> Heart disease/murmur/MVP |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> High Cholesterol/triglycerides |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> High blood pressure |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> Phlebitis/blood clots in legs/lungs |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> Stroke/TIA/"mini stroke" |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> Migraines/Headaches |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> Numbness/sensory loss |
| 16. | <input type="checkbox"/> | <input type="checkbox"/> Seizures/epilepsy |
| 17. | <input type="checkbox"/> | <input type="checkbox"/> Stomach/Bowel problems |
| 18. | <input type="checkbox"/> | <input type="checkbox"/> Liver disease/jaundice |
| 19. | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis/Mono |
| 20. | <input type="checkbox"/> | <input type="checkbox"/> Gall Bladder disease/stones |
| 21. | <input type="checkbox"/> | <input type="checkbox"/> Diabetes/"sugar" |
| 22. | <input type="checkbox"/> | <input type="checkbox"/> Thyroid problems |
| 23. | <input type="checkbox"/> | <input type="checkbox"/> Asthma/Breathing Problems |
| 24. | <input type="checkbox"/> | <input type="checkbox"/> Chronic Cough/TB |
| 25. | <input type="checkbox"/> | <input type="checkbox"/> Abnormal Uterus/fibroids |
| 26. | <input type="checkbox"/> | <input type="checkbox"/> Pelvic infection/pain/PID |
| 27. | <input type="checkbox"/> | <input type="checkbox"/> Recurrent vaginal infection |
| 28. | <input type="checkbox"/> | <input type="checkbox"/> Frequent bladder infection |
| 29. | <input type="checkbox"/> | <input type="checkbox"/> Bladder/kidney problems |
| 30. | <input type="checkbox"/> | <input type="checkbox"/> Breast problems/lump/surgery |
| 31. | <input type="checkbox"/> | <input type="checkbox"/> Anemia (low iron) |
| 32. | <input type="checkbox"/> | <input type="checkbox"/> Blood Clotting disorder |
| 33. | <input type="checkbox"/> | <input type="checkbox"/> Blood transfusion |
| 34. | <input type="checkbox"/> | <input type="checkbox"/> Sickle cell anemia/trait |
| 35. | <input type="checkbox"/> | <input type="checkbox"/> Acne |
| 36. | <input type="checkbox"/> | <input type="checkbox"/> Chronic rash/itching |
| 37. | <input type="checkbox"/> | <input type="checkbox"/> Other skin problems |
| 38. | <input type="checkbox"/> | <input type="checkbox"/> Arthritis/joint pain |
| 39. | <input type="checkbox"/> | <input type="checkbox"/> Broken bones/fractures |
| 40. | <input type="checkbox"/> | <input type="checkbox"/> Eye problems |
| 41. | <input type="checkbox"/> | <input type="checkbox"/> Hearing problems |
| 42. | <input type="checkbox"/> | <input type="checkbox"/> Frequent nosebleeds |
| 43. | <input type="checkbox"/> | <input type="checkbox"/> Frequent sore throat |
| 44. | <input type="checkbox"/> | <input type="checkbox"/> Teeth/gum problems |
| 45. | <input type="checkbox"/> | <input type="checkbox"/> Depression/Anxiety |
| 46. | <input type="checkbox"/> | <input type="checkbox"/> In counseling |
| 47. | <input type="checkbox"/> | <input type="checkbox"/> Severe mood swings |
| 48. | <input type="checkbox"/> | <input type="checkbox"/> Ovarian cysts/Endometriosis |
| 49. | <input type="checkbox"/> | <input type="checkbox"/> Abnormal pap smears |

CERVICAL PROCEDURES:

50. Colposcopy/Cryo (Freezing)
51. LEEP/Laser/Cone Biopsy

Staff Notes

