ALL FEMCARE PROFESSIONALS
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NAME_______________________ Age_______ S M W D Sep Occupation_______________
Husband_______________________ Age_______ Health_______________ Occupation_______________
Years Married___________ # of previous marriages_______ Family Doctor_______________________
Primary Language_______________
Name and Location of Pharmacy Most Often Used_______________________________________

OBSTETRICAL HISTORY: (Indicate Number of)
Full Term Babies _______ Premature _______ Stillborn _______ Miscarriages _______ Abortions _______

CONTRACEPTIVE METHOD: (Currently Using) Condoms Diaphragm IUD Sponges Depo-Provera Norplant Birth Control Pills Tubal Vasectomy None

Date of Last Mammogram: _______________ Normal __________ Abnormal __________

Date of Last Pap Smear: _______________ Normal __________ Abnormal __________
Treatment If Any for Abnormal Pap Smear: _______________________________________

FAMILY HISTORY: Has Any Blood Relative Ever Had (Please Circle)

Birth Defects
Blood Clotting Problems
Diabetes
Epilepsy
Heart Disease or Attacks
High Blood Pressure
Kidney Disease
Mental Disorder
Stroke
Thyroid
Tuberculosis

FEMALE CANCER HISTORY: (Please circle and indicate if it is your Sister, Mother, Maternal Aunt, or Maternal Grandmother)
Breast __________ Ovarian __________ Uterine __________ Cervical __________

	Age	Status of Health / Cause of Death
Mother		/
Father		/
Brothers		/
Sisters		/
Siblings Not Living		/

SOCIAL HISTORY:
Smoking
Do You Smoke? _______ How Many Packs Per Day? _______ How Many Years? _______

Alcohol
Do You Drink? _______ Rare Social Moderate History of Alcoholism
History of Drug Abuse or Addiction? _______________________________________

ID# ____________

PERSONAL MEDICAL HISTORY: (Please Circle)

AIDS
Anemia
Arthritis
Asthma
Birth Defects
Bladder Infections
Bleeding Problems
Blood Transfusion
Bowel Problems
Brain or Spinal Problems
Breast Problems
Cancer
Chlamydia
Condyloma/HPV
Diabetes
Gallbladder Problems
Gonorrhea
Headaches
Hepatitis
Herpes
High Blood Pressure
HIV
Infection of Tubes/Ovaries PID
Kidney Problems
Liver Problems
Mitral Valve Prolapse
Phlebitis
Seizures
Syphilis
Thyroid Problems
Tuberculosis
Ulcers
Varicose Veins
Visual/Hearing Problems
Other: ____________

PLEASE LIST YOUR PREGNANCIES IN CHRONOLOGICAL ORDER BELOW:

Year	Sex	Weight	Vaginal/C-Section	Delivery Doctor	Name of Child

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

Year	Surgery	Reason

ARE YOU ALLERGIC TO ANY MEDICATIONS? Yes No

List ____________

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

(This includes all prescription and nonprescription medication)

Medication Name	Dosage	Reason for Taking

GYNECOLOGICAL HISTORY:

Age at initial menstrual period ______ Onset of last period ____________ Period every _____ days

Lasting______days Menses Reg. or Irreg. Any problems with periods ____________

MAJOR HEALTH CONCERN AT PRESENT: ____________