Axia WOMEN'S HEALTH

Medical History Form

Name:	DOB: / /	Date:

Special assistance needed for care	☐ None ☐ Lifting Assistance ☐ Wheelchair Accessibility ☐ Interpreter ☐ Other____

CURRENT MEDICATIONS: List all current prescriptions and over-the-counter medications including dose and frequency

ALLERGIES:

☐ No Known Allergies	☐ Adhesive Tape	☐ Cephalosporins	☐ Codeine	☐ Erythromycin
☐ Iodine	☐ Latex	☐ Lidocaine	☐ Demerol	☐ Morphine
☐ NSAIDS (Advil, Aleve)	☐ Penicillin	☐ Salicylates	☐ Succinimides	☐ Sulfa
☐ Tetracyclines	☐ Pertussis Vaccine	☐ Other ____________________________________		
Food Allergies:	☐ None	☐ Eggs	☐ Dairy	☐ Nuts
	☐ Shellfish	☐ Gluten	☐ Other ______________________	

MEDICAL HISTORY: (Select all that apply)

☐ None	☐ Anemia	☐ Anxiety	☐ Arthritis	☐ Asthma
☐ Autoimmune Disorder	☐ Blood/Clotting Disorder	☐ Blood Transfusion	☐ Colon Cancer	☐ Depression
☐ DES Exposure	☐ Diabetes	☐ DVT/PE (blood clot in leg/Lungs	☐ Eating Disorder	☐ Fracture
☐ GERD/Acid Reflux	☐ Gallbladder Disease	☐ GI Issues (bowel trouble/IBS)	☐ Glaucoma	☐ Heart Disease
☐ Hepatitis/Liver Disease	☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Kidney Stones
☐ Lung Problems	☐ Migraine Headaches	☐ Mitral Valve Prolapse	☐ Osteoporosis	☐ Rectal Cancer
☐ Seizures	☐ Substance Abuse	☐ Stroke	☐ Thyroid Disease	☐ Vision or Hearing Impairment
☐ Other ____				

GYN HISTORY: (Select all that apply)

☐ None	☐ Breast problems	☐ Endometriosis	☐ Fibroids	☐ Pelvic inflammatory disease
☐ Polycystic Ovarian Syndrome (PCOS)	☐ Breast Cancer	☐ Cervical Cancer	☐ Endometrial Cancer	☐ Ovarian Cancer
☐Uterine Cancer	☐ Other ______________________________			

SURGICAL HISTORY: (Select all that apply)

☐ None	☐ Appendectomy	☐ Back Surgery	☐ Breast Augmentation	☐ Breast Biopsy
☐ Breast Reduction	☐ Breast Surgery	☐ D&C	☐ Hysteroscopy	☐ Foot Surgery
☐ Gallbladder Removal	☐ Hip Surgery	☐ Knee Surgery	☐ Oral Surgery	☐ Shoulder Surgery
☐ Thyroid Surgery	☐ Tonsillectomy	☐ Bilateral Tubal ligation	☐ Hysterectomy	☐ Ovaries Removed
☐ Laparoscope	☐ Uterine Ablation	☐ C-Section	☐ Other______________________	

HEALTH MAINTENANCE: answer all that apply with Date and Results

Last Pap Smear	
Last HPV Test	
History of abnormal pap If yes, indicate treatment	☐ None ☐ Yes ☐ No treatment ☐ Freezing ☐ LEEP/cone ☐ Laser
Last Routine Screening Labs	
Last Mammogram	
Last Colonoscopy	
Last Bone Density Scan/DEXA	

MENSTRUAL HISTORY – If you ARE having menstrual cycles, please answer the following. Otherwise, skip to next section	
At what age did your periods start	
What was the first day of your last period	
What is the length of time between periods	☐ Irregular ☐ 21-32 days ☐ less than 21 days ☐ 33-44 days ☐ more than 45 days
How long does your period last	☐ 2-7 days ☐ longer than 7 days
How would you describe your flow	☐ Light ☐ Moderate ☐ Heavy
Do you have pain/cramping associated with your periods	☐ No pain/cramping ☐ Mild discomfort ☐ Moderate discomfort ☐ Severe pain/cramping
Any other symptoms associated with your period	☐ None ☐ Headaches ☐ Bloating ☐ Irritability ☐ Migraines ☐ Weight Gain ☐ Mood swings ☐ Nausea ☐ Bowel issues

MENSTRUAL HISTORY – If you ARE NOT having menstrual cycles, please answer the following.	
Reason for no menses	☐ Menopausal ☐ Pregnant/Breastfeeding ☐ IUD in place ☐ Hysterectomy ☐ Unknown
Menopausal - What age did this occur	
Menopausal - Any current menopausal symptoms	☐ None ☐ Hot Flashes/Night Sweats ☐ Memory Loss ☐ Headaches ☐ Irritability ☐ Weight gain ☐ Decrease Libido ☐ Vaginal Dryness
Menopausal - Are you taking any treatments	☐ None ☐ Hormones ☐ OTC treatments
IUD - What type is in place	☐ Mirena ☐ Liletta ☐ Kyleena ☐ Skyla ☐ Paragard ☐ Unknown
IUD – When was it placed	

SEXUAL HISTORY	
Have you ever been sexually active	☐ Yes ☐ No (Skip to next section)
Are you currently sexually active	☐ Yes ☐ No
Age of first sexual encounter	
Have you had more than 5 lifetime partners	☐ Yes ☐ No
Type of birth control	☐ Nothing ☐ Withdrawal ☐ Condoms ☐ Diaphragm ☐ Spermicide ☐ Oral Contraceptives ☐ Contraceptive Patch ☐ Contraceptive Vaginal Ring ☐ Depo Provera ☐ Nexplanon ☐ IUD ☐ Tubal ligation ☐ Vasectomy ☐ Hysterectomy
Have you ever been diagnosed with a Sexually Transmitted Infection (STI)	☐ None ☐ Human Papilloma Virus (HPV) ☐ Chlamydia ☐ Herpes Simplex Virus (HSV) ☐ Gonorrhea ☐ Syphilis ☐ Trichomoniasis ☐ Hepatitis B ☐ Hepatitis C ☐ Human Immunodeficiency Virus (HIV)

BLADDER HEALTH	
Do you ever leak urine when you cough, sneeze, laugh or exercise?	☐ Yes ☐ No
Do you ever leak urine on the way to the bathroom or can't get to the bathroom on time?	☐ Yes ☐ No
Do you have a history of recurrent urinary tract infections?	☐ Yes ☐ No
Do you go to the bathroom frequently and/or get up multiple times at night?	☐ Yes ☐ No

OB HISTORY			
Total # of Pregnancies		Total living children	
# of full-term pregnancies (37 weeks or greater)		# of preterm pregnancies (less than 37 weeks)	
# of miscarriages/abortions		# of ectopic (tubal) pregnancies	

Please fill out the following to the best of your recollection regarding your prior pregnancies:

	Date MO/YR	SEX	GA WEEKS	TYPE of DELIVERY	BIRTH WEIGHT	ANESTHESIA	LENGTH of LABOR	WEIGHT GAIN
PREG 1		M or F		Vaginal or C-Section	lbs. oz.			
Comments and complications:								
PREG 2		M or F		Vaginal or C-Section	lbs. oz.			
Comments and complications:								
PREG 3		M or F		Vaginal or C-Section	lbs. oz.			
Comments and complications:								
PREG 4		M or F		Vaginal or C-Section	lbs. oz.			
Comments and complications:								

Patient Name ______________________________ Date of Birth__________________

FAMILY HISTORY: Please check all that apply								☐ Family history unknown/adopted
Medical Condition	Mother	Father	Sibling	Child	Mat GM	Mat GF	Pat GM	Pat GF
Bleeding Disorder								
Heart Disease								
Diabetes								
Hypertension								
Breast Cancer								
Ovarian Cancer								
Colon Cancer								
Uterine Cancer								
Stroke								
Thyroid Disorder								
Osteoporosis								
Auto Immune Disorders								
Mental Illness								
Other								

SOCIAL HISTORY	
Tobacco/Smoking	
Do you now or have you ever smoked or used tobacco products?	☐ Yes ☐ No (Skip to next section)
Age you started smoking	
Type of Product	☐ Cigarettes ☐ e-cigarette ☐ Vape ☐ Chewing tobacco
Amount of Use	☐ Daily ☐ Some days but not every day ☐ 5 or less/day ☐ 6-10/day ☐ 11-20/day ☐ 21-30/day ☐ more than 31/day
Former Smoker – Age you stopped	
Alcohol	
Have you had a drink containing alcohol in the last year?	☐ Yes ☐ No (Skip to next section)
How often did you have a drink containing alcohol in the last year	☐ Less than monthly ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4 or more times per week
Recreational Drugs	
Have you ever used any recreational drugs	☐ Yes ☐ No (Skip to next section)
Type of Use	☐ Marijuana ☐ Heroin ☐ Cocaine ☐ Crack ☐ Methamphetamine ☐ Opiates ☐ Ecstasy ☐ LSD ☐ PCP ☐ Ketamine ☐ Other ________________________________
How long since you last used	
How often do you use	
Are you interested in a treatment program	☐ Yes ☐ No ☐ Unsure
Domestic Violence/Abuse	
Have you ever or are you currently experiencing any type of abuse?	☐ Yes ☐ No (Skip to next section)
Type of Abuse and Status	☐ Verbal ☐ Physical ☐ Sexual
Abuse Status	☐ History in the past ☐ Have a restraining order ☐ Feels unsafe at home ☐ have a safety plan
Has your partner ever threatened you or made you feel afraid?	☐ Yes ☐ No
Does your partner or someone important to you hurt you physically or emotionally?	☐ Yes ☐ No
Other	
Would you object to blood products in the event of an emergency?	☐ Yes ☐ No

Immunizations: Have you had any of the following?							
Chicken Pox	☐ Yes	☐ No	Year	Gardasil	☐ Yes	☐ No	Year
Tdap	☐ Yes	☐ No	Year	Influenza	☐ Yes	☐ No	Year
Hepatitis B	☐ Yes	☐ No	Year	Pneumonia	☐ Yes	☐ No	Year
Rubella	☐ Yes	☐ No	Year	COVID	☐ Yes	☐ No	Year

Patient Name ____ Date of Birth__________________________