Institute for Women's Health and Body
Health History Update

Date: _____ Patient Name: _____ DOB: _____

Reason for today's visit: _____

Date of last Pap smear: _____ Mammogram: _____ Colonoscopy: _____ Bone Density: _____

If applicable :
Do you use birth control/type: _____ 1st day of last menstrual period: _____

In the past year have you had any pregnancies/result: _____

Medications (& doses):_____

_____

Vitamins and herbal supplements: _____

In the past year have you had any changes to your health? _____

_____

Any other information that the doctor should be informed of? _____

_____

Check if any of the following apply to you

___ Have not had any Pap tests within the last seven years.
___ Are the daughter of a woman who took DES.
___ Began having sexual intercourse before age 16.
___ Have had five or more sexual partners in your life.
___ Have a history of sexually transmitted disease.
___ Cervical or vaginal cancer
___ Vaginal dryness/pain/discomfort with intercourse
___ Menopause symptoms such as hot flashes, night sweats, insomnia, mood swings
___ Urinary incontinence, frequency or urgency
___ Osteoporosis/osteopenia
___ Pelvic pain
___ Vaginal or uterine prolapse
___ Fibrocystic/dense breasts
___ Uterine fibroids

Signature_____ Date_____