Patient Name_____

DOB____/___/___ Todays Date:___/___/___

Middletown Community Health Center, Inc.
Female Health Assessment Form
18-64 years old

Date you were last seen by a Doctor/Hospital: _____/_____/_____
Name of Doctor/Hospital _____ Phone #:____-____-____

MEDICAL HISTORY

Do you have any Allergies? Yes ☐ No ☐ If yes fill out section below

ALLERGY	REACTION	HOW BAD IS IT (Low, Mod, Severe)

Are you taking any MEDICATION? YES (continue below) NO ☐
Include ALL Medications OVER THE COUNTER AND HERBAL

MEDICATION NAME	DOSE	FREQUENCY

Have you ever had an HIV test? Yes ☐ No ☐ Would you like one TODAY? Yes ☐ No ☐
HOSPITALIZATIONS within the last year? Yes (continue below) No ☐

DATE	OPERATION/ILLNESS/INJURY	HOSPITAL

DATE	SCREENING			DATE	IMMUNIZATION
	Mammogram : Results Pos ☐ Neg ☐				TETANUS
	Pap Test (name & # of where) Results Pos ☐ Neg ☐				MMR Vaccine
					Flu Vaccine
	Colonoscopy/At home stool test kit (FOBT) name & # of where Results Pos ☐ Neg ☐				HEP A
					HEP B
					SHINGLES
	DENTAL EXAM				
	STD		HEP C	EKG/ECHO	
	Bone Density Exam			STRESS TEST	PNUEMONIAVaccine

MEDICAL HISTORY (checkifyouhave/hadany of thebelow)

	ACTIVE TUBERCULOSIS		GENDER TRANSFORMATION SURGERY		PNEUMONIA
	ALCOHOLISM		HEADACHES		POSITIVE TB SKIN TEST
	ANEMIA		HEART PROBLEMS		PULMONARY DISEASE
	ANXIETY		HEPATITIS C		RHEUMATIC FEVER
	ARTHRITIS		HIGH BLOOD PRESSURE		SEIZURES/EPILEPSY
	BLOOD DISORDER		HIV/AIDS		SICKLE CELL DISEASE
	CANCER/TUMOR		KIDNEY/BLADDER DISEASE		SKIN PROBLEMS
	CONSTIPATION		LIVER DISEASE		STD
	COPD		MIGRAINES		STROKE
	DEPRESSION		OSTEOPOROSIS		STOMACH/INTEST PROBLEMS
	DIABETES		PANIC ATTACKS		THYROID PROBLEMS
	UTI		OTHER		

PatientName:_____ DOB: _____ Date: _____

FAMILY HISTORY					
	ALCOHOLISM		GALLBLADDER DISORDER		OSTEOPOROSIS
	ARTHRITIS		HEPATITIS		SEIZURES/EPILEPSY
	ASTHMA		HEMOPHILIA		SICKLE CELL DISEASE
	BLOOD DISORDER		HIGH BLOOD PRESSURE		STOMACH DISORDER
	CANCER/TUMOR		INTESTINAL DISEASE		STROKE
	DEPRESSION		KIDNEY/BLADDER DISEASE		TUBERCULOSIS
	DIABETES		LIVER DISEASE		

SOCIAL HISTORY

YES NO

__ __ Do you regularly use tobacco? How many Cigarettes per day ___ Pipe ___ Cigars_____ Vaping____ Years using _____ Packs per day _____

__ __ Do you drink beer, wine or hard liquors? Amount _____ Frequency _____

__ __ Do you use or have ever used marijuana, cocaine, inhalants or other street drugs? Which Drug _____ Frequency _____ Amount _____

__ __ Do you usually drink caffeine beverages? How much? _____

__ __ Have you ever experienced unwanted sexual touch, verbal or physical violence?

__ __ Are you afraid anyone might hurt you?

__ __ Do you avoid eating for 24 hours or more?

__ __ Do you eat laundry starch, clay or dirt on occasion?

__ __ Are you on a special diet? Explain_____

__ __ Have you gained or lost more than 10 pounds during the last six months?

__ __ Do you exercise regularly?

__ __ Have you ever had sexual intercourse? Y☐ N☐ Same sex? Y ☐ N ☐ If yes, age you first had intercourse ____

__ __ How many sexual partners have you had in the past six months? ____ In your life? ____

FEMALE/GYNECOLOGICAL-MENSTRUAL HISTORY

__ __ Are you concerned that you may have been exposed to Sexually Transmitted Diseases (STD) such as Chlamydia, gonorrhea, HIV, herpes, syphilis or genital warts?

__ __ Do you believe you are at high risk of getting HIV/STD's? **Do you want information on preventative medications for HIV? YES ☐ NO ☐**

__ __ **Do you want to be screenedfor HEREDITARY& GENETIC Cancers ?**

__ __ Are your periods regular?

__ __ Do you plan to become pregnant in the next 12 to 18 months?

__ __ Have you ever been pregnant? No ☐

Yes: How many pregnancies_____ Live Births_____ Abortions____ Miscarriages_____

Birth of your baby was: VAGINAL ☐ C-SECTION ☐ Weight_____

FULL TERM ☐ PREMATURE ☐

Methods of Contraception used **Are you currently using this method?**

☐ Pills ☐ Condom ☐ Y ☐ N

☐ Depo-provera ☐ Tublal Ligation

☐ Abstinence ☐ IUD

☐ Hysterectomy ___/___/___ Age:_____