

MONTGOMERY COUNTY HEALTH DEPT. WOMEN'S HEALTH MEDICAL HISTORY

COMPLETE FORM IN BLACK INK AND BRING TO CLINIC - PLEASE PRINT

Date _____ Social Security Number _____ Age _____ Birthdate _____
 LAST FIRST M.I.

NAME _____ Maiden _____ Marital Status _____
 Address _____ CITY _____ ZIP _____
 Home Phone _____ Best Time _____ Cell Phone _____
 Work Phone _____ Best Time _____ E-Mail _____

Contact Person: Name _____ Relationship _____
 Address _____ Phone _____

FOR TEENS ONLY: CAN APPOINTMENT BE SENT TO YOUR HOME? YES ___ NO ___ PARENTS AWARE? YES ___ NO ___
 CAN TELEPHONE CALLS BE MADE TO YOUR HOME? YES ___ NO ___

RACE: WHITE ___ BLACK ___ NATIVE AMERICAN ___ ASIAN ___ OTHER ___ HISPANIC ORIGIN: YES ___ NO ___

Number of school years completed. ___ Are you a student? YES ___ NO ___

Are you in a relationship in which you have been sexually, physically or verbally hurt or threatened?

YES ___ NO ___ Have you ever been? _____

This includes all wages, unemployment benefits, Social Security payments, child support, alimony, self-employment interest, AFDC, disability payments, scholarships, workstudy grants, etc.

Sources of Income: Self ___ Spouse ___ Partner ___ Parents ___ Public Assistance ___ Other ___

Income before taxes, per week _____ or month _____ or annual _____

Number of people, including yourself, supported by this income _____

Do you have: Private Insurance YES ___ NO ___ Does Insurance Cover Well Woman Exam YES ___ NO ___

Medicaid Number _____

I AM HERE TODAY BECAUSE: _____

Your private doctor(s)/clinic: _____ City/State _____

Medical care in past year (include over the counter, vitamin, herbs): _____

Medications used in past year: _____

Have you ever had a pelvic exam? YES ___ NO ___ Date of last Pap Smear _____

How did you hear about our Women's Health services? _____

DO YOU HAVE A HISTORY OF:

Hepatitis B vaccination? NO ___ YES ___ If Yes, Dates: _____, _____, _____

Hepatitis A vaccinations? NO ___ Yes ___ If yes, Dates: _____, _____

Date of last Tetanus vaccination. _____

MMR Dates _____, _____ Vaccinated ___ Per DOB

___ Mono ___ Cancer ___ Stroke ___ Diabetes ___ Genetic problems

___ Rheumatic fever ___ Obesity ___ Sickle Cell ___ Jaundice/hepatitis

___ Thyroid disease ___ Other(Specify) _____

Hospitalizations/Surgery Type/Dates _____

Major illness/Injuries Type/Dates _____

Allergies(drug, metal, skin or irritants) _____

If born before 1972 did your mother take DES(hormone)while pregnant with you?

YES ___ NO ___ Unknown _____

Have your birth parents, brothers or sisters ever had any of the following?(if adopted, disregard)

	YES	NO	?	Staff comments
1. Death from heart attack before age 50				
2. High blood pressure				
3. Breast, uterine, ovarian, colon cancer				
4. Diabetes				
5. High blood fat levels(i.e. cholesterol)				
6. Genetic problems				

ON A TYPICAL DAY:

How many hours do you sleep? _____

How many cigarettes do you smoke? _____

How many servings of the following do you eat in a typical day?

fruits _____ nuts/beans _____

breads/cereals _____ eggs/meats _____

milk/dairy products _____ vegetables _____

coffee/tea/cola _____

IN A TYPICAL WEEK HOW OFTEN DO YOU:

Use alcohol _____

Use street drugs _____

Exercise (type) _____

NURSE SIGNATURE _____ DATE _____

