1. Last Name First Name MI

2. Patient Number | | | | | | | | | | — | H |

3. Date of Birth Month Day Year

4. Home Address

5. Age: _____ 6. Marital Status: _____

7. County of Residence | | | |

8. Race 1. □ White 2. □ Black 3. □ Am. Ind. 4. □ Asian 5. □ Native Hawaiian/Other Pacific Islander 6. □ Other

Ethnicity: Hispanic Origin? 1. □ Yes 2. □ No

CONFIDENTIAL

North Carolina Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

FEMALE SELF-HISTORY FORM

If you are unsure about any question, leave it blank and ask the nurse for help.

A. IMPORTANT INFORMATION (Please complete the following)

1. What is the reason for your visit today? _____
2. Do you feel that you are in good health? □ Yes □ No
3. Emergency contact: _____
4. May we contact you by mail? □ Yes □ No by phone? □ Yes □ No Your phone # is _____
5. Are you seeing another doctor for any reason? □ Yes □ No
6. Do you have any allergies? □ Yes □ No If yes, what_____
7. Highest grade completed in school_____
8. Occupation_____

B. List Significant Illness, Hospitalizations, Operations, Accidents and Physical Trauma:

_____

C. SELF & FAMILY MEDICAL HISTORY (Please put an **X** under **YOU** if you've had any of the following. Put an **X** under **FAMILY** if either a parent, grandparent, brother, sister or child of yours has had any of the following)

YOU / FAMILY	YOU / FAMILY
1. □ □ Abuse (physical, sexual, verbal, or emotional)	17. □ □ Hernia
2. □ □ Anemia, Sickle Cell Disease or Trait, Blood disorder	18. □ □ High cholesterol, High blood pressure, Stroke
3. □ □ Anorexia, Bulimia, other eating disorders	19. □ □ HIV, AIDS
4. □ □ Arthritis, joint problems, back problems	20. □ □ Kidney or bladder problems, stones, dialysis
5. □ □ Asthma, Bronchitis, other breathing problems	21. □ □ Migraine or severe headaches
6. □ □ Birth defects, genetic problems, Cystic Fibrosis	22. □ □ Pain, numbness, broken veins or infection in arms or legs
7. □ □ Bleeding problems, blood clots in legs or lung, etc.	23. □ □ Physical disability
8. □ □ Bowel problems	24. □ □ Tuberculosis (TB)
9. □ □ Breast lumps, discharge, tenderness, other problems	25. □ □ Rectal pain or bleeding, hemorrhoids or "piles"
10. □ □ Cancers, tumors (including cervical or uterine)	26. □ □ Female Problems
11. □ □ Depression, anxiety, mental illness	27. □ □ Seizures ("fits")
12. □ □ Diabetes (sugar problems), Gestational Diabetes	28. □ □ Stomach pain, cramps, ulcers
13. □ □ Eye problems, blurred vision or spots	29. □ □ Thoughts of harming self or others
14. □ □ Fainting, dizzy spells	30. □ □ Thyroid problems
15. □ □ Heart disease, heart problems, chest pain, Rheumatic Fever	31. □ □ Transfusions of blood or blood products
16. □ □ Hepatitis, liver problems, gallbladder problems	32. □ □ Twins, Triplets or more

Provider/Nurse Comments ONLY:

D. Infectious Diseases (Please put an (X) by all that you have had)

1. □ Measles 2. □ Chicken Pox 3. □ Mumps 4. □ Any Sexually Transmitted Diseases
5. □ Rubella 6. □ Hepatitis A or B 7. □ Tetanus 11. □ Other: _____
8. □ Scarlet Fever 9. □ Whooping Cough 10. □ Meningitis

E. Vaccine History - May use NCIR print out

	Date	Vaccine	Date	Other Vaccines	Date
Tetanus shot (Td/Tdap)	_____	Chicken Pox	_____	Influenza (Flu)	_____
Measles shot (MMR)	_____	HPV	_____	Twinrix	_____
Pneumonia	_____	Hepatitis B series	_____	other	_____

F. Do You:

1. Smoke or use smokeless tobacco	□ Yes	□ No	If yes, how much? _____ How long?_____
2. Drink alcohol	□ Yes	□ No	If yes, how much? _____ How long?_____
3. Take street drugs	□ Yes	□ No	If yes, what? _____ How long?_____
4. Take vitamins with folic acid	□ Yes	□ No	
5. Take diet or herbal supplements	□ Yes	□ No	If yes, what? _____
6. Take any medications (prescription or over the counter)	□ Yes	□ No	If yes, what? _____
7. Have any dental problems?	□ Yes	□ No	If yes, what? _____

G. APPETITE/DIETARY/EXERCISE/SAFETY INFORMATION

1. Eat 5 fruits and vegetables a day? □ Yes □ No
2. Eat fewer than 2 meals a day? □ Yes □ No
3. Have trouble getting food? □ Yes □ No
4. Want to eat non-food items like dirt, clay, starch? □ Yes □ No
5. Exercise regularly (walk, swim, bike or other activity 30 minutes 3X/week)? □ Yes □ No
6. Have contact with chemicals/other hazards? □ Yes □ No
7. Use seatbelt while driving/riding in car? □ Yes □ No
8. Notice a weight change of more than 10 lbs? □ Yes □ No
9. Live in a safe place? □ Yes □ No
10. Have smoke detectors at home? □ Yes □ No
11. Have exposure to second hand smoke? □ Yes □ No
12. Have problems with transportation? □ Yes □ No

H. SEXUAL & CONTRACEPTIVE HISTORY

1. Age at first intercourse? _____
2. Date of last intercourse? _____
3. Are you feeling pressured to have sex? □ Yes □ No
4. Number of partners in past 6 months? _____
5. How many sexual partners have you had? _____
6. Do you use condoms every time you have sex? □ Yes □ No
7. Do you have sex with:
   □ Men only □ Women only □ Both men and women
8. Does your partner have sex with:
   □ Men only □ Women only □ Both men and women
9. Do you have pain or bleeding with sex? □ Yes □ No
10. Do you or your partner inject any drugs? □ Yes □ No
11. Have you had an HIV test? □ Yes □ No
    If yes, when? _____
12. Has your partner had an HIV test? □ Yes □ No
    If yes, when? _____
13. Do you want HIV testing today? □ Yes □ No
14. Does your partner have sex with more than one person? □ Yes □ No
15. Check the ways you have sex: □ vaginal □ oral □ anal
16. Have you had recent chills or fever? □ Yes □ No
17. Have you or your partner ever had a sexually transmitted disease (Gonorrhea, Chlamydia, Syphilis, Herpes, Hep B, other)? (If yes, please circle which sexually transmitted disease) □ Yes □ No
18. What have you used for birth control in the past?
    □ Pills □ Depo Shots □ Foam/Gel □ Diaphragm □ IUD
    □ Condoms □ Withdrawal (Pull out) □ Abstain □ Other □ None
19. What are you using now? _____
20. Are you satisfied with method? □ Yes □ No
21. If no, what method do you wish? _____
22. Do you or your partner want to become pregnant? □ Yes □ No
    If yes, when?

I. MENSTRUAL/GYNECOLOGICAL HISTORY

1. What age did your menstrual periods begin? _____
2. When did your last period start? _____
3. How many days did it last? _____
4. Was it normal? □ Yes □ No
5. How often do you have your periods? _____
6. Any problems? _____
7. Do you douche? □ Yes □ No
8. Do you have a vaginal discharge or odor? □ Yes □ No
9. Do you examine your breasts? □ Yes □ No
   If yes, how often? _____
10. Have you ever had a pelvic exam? □ Yes □ No
    If yes, date of last pelvic exam _____
11. Date of your last Pap smear _____
12. Have you ever had an abnormal Pap? □ Yes □ No
    If yes, what was done _____
13. Have you ever had a mammogram? □ Yes □ No

J. OBSTETRICAL HISTORY

1. If you were born before 1971 did your mother take DES when she was pregnant? □ Yes □ No □ N/A
2. Have you ever been pregnant? □ Yes □ No
   If yes, how many times? _____
3. How many were:
   Full term? ____ Premature? ____ Stillborn? ____
4. How many times did you have:
   A miscarriage? ____ An abortion? ____
5. Did any babies weigh less than 5½ lbs. at birth? □ Yes □ No
6. Did any babies weigh more than 9 lbs at birth? □ Yes □ No
7. Are you breast feeding now? □ Yes □ No
8. Did you have a positive Group B Strep test with a previous pregnancy? □ Yes □ No
9. Did you have any problems with any pregnancies? □ Yes □ No

Provider/Nurse Comments ONLY:

Patient's Signature: _____ Date: _____

Signature of Interpreter (if used): _____ Date: _____

Reviewed By: _____ _____ _____ _____
(Nurse's signature) (Date) (Provider's signature) (Date)