simple
Wellness • Fitness • MedSpa
phone: 785-856-3030
fax: 866-623-6314
mySimpleHealthcare.com

PLEASE PRINT!

FEMALE SELF-HISTORY

Name: _____ _____ **DOB:** _____ **Age:** _____

I am a: ☐ New patient ☐ Established patient
If new, how did you hear about us? ☐ Family/friend ☐ Yellow pages ☐ Internet ☐Newspaper ☐ Other

Date of last tetanus vaccination: _____ **Flu vaccination:** _____ **Shingles vaccination:** _____

Drug Allergies: _____

Fun Facts
Favorite Childhood Memory: _____
Favorite Song: _____
Favorite thing to drink (Coffee/tea/etc.): _____

Please list any medications you are taking OR over the counter meds-you may attached a list.

Check if refill needed:

☐ _____ ☐ _____
☐ _____ ☐ _____
☐ _____ ☐ _____
☐ _____ ☐ _____

Name of pharmacy you plan to use: _____

Reason for visit today: _____
_____

GYN History:
Date last period began: _____ If you do not have periods, what year did you stop? _____
Current method of birth control: _____

Medical History:
Please check if you currently or have ever had any of the following:

☐ Asthma ☐ COPD/Emphysema ☐ Cancer, if yes, list type: _____
☐ Diabetes ☐ Depression/Anxiety ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol
__Thyroid __ Blood Clots

Other medical problems not listed above:_____

Please list any surgical procedures you have had: _____

When was your last pap smear? _____ Have you ever had an abnormal pap? _____

Year/treatments for abnormal pap: _____

Number of times pregnant: _____ Ages of children: _____
Are you considering pregnancy in the next year? Y N

Social History:

Are you: ☐ single ☐ married ☐ divorced ☐ widowed ☐ single but in long-term relationship

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Patient Name_____ DOB_____

Are you currently sexually active? Y N Any new partners since your last exam? Y N

Are you interested in getting tested for sexually transmitted diseases? Y N

What is your current occupation? _____

Do you smoke? Y N If yes, how much? _____

If no, did you ever smoke? Y N If yes, how much & when did you quit? _____

How often do you use alcohol? ☐ Never ☐ Rarely ☐ 2-3 times a month ☐ 2-3 times a week ☐ Daily

Do you use any recreational drugs? Y N If yes, what kind? _____

Do you exercise? Y N If yes, how often and what type? _____

Family Medical History:
(Indicate who has problem: M-Mother F-Father GM-Grandmother GF-Grandfather B-Brother S-Sister)

Allergies	_____	Heart disease/Stroke	_____	Seizures	_____
Arthritis	_____	High blood pressure	_____	Vision/Hearing Problems	_____
Blood disorder/Sickle cell	_____	Kidney/Liver disease	_____	Ulcers/Colitis	_____
Cancer	_____	Lung disease	_____	Urinary/Bowel problems	_____
Diabetes	_____	Mental illness	_____	Other	_____
Drug/alcohol abuse	_____	Obesity	_____		

Please circle if you are having any of the following problems:

GEN: decreased energy change in appetite change in weight fever chills body aches night sweats

EYES: vision changes discharge irritation sensitivity to light

ENT: hearing problem ear pain runny nose congestion sneezing hoarseness sore throat sinus pain

Resp: shortness of breath cough wheezing coughing blood

Cardiac: chest pain irregular heartbeat fainting swelling murmur

GI: nausea vomiting bloating diarrhea heartburn abdominal pain blood in stool change in stools

GU: frequent urination incontinence blood in urine pain with urination irregular periods painful periods

Muscular: back pain neck pain joint stiffness joint swelling muscle pain

Neuro: weakness dizziness seizures headaches loss of consciousness

Skin/Breast: rash concerning skin lesions breast problems

Psych: nervousness mood changes depression problems sleeping

Endocrine: hair loss heat or cold intolerance excessive body hair increased thirst frequent urination

Heme: easy bruising swollen nodes abnormal bleeding

Allergy: environmental allergies immune deficiency

Health Maintenance:
Date of last bone density screening: _____ Results: ☐ normal ☐ abnormal ☐ don't know
Date of last cholesterol screening: _____ Results: ☐ normal ☐ abnormal ☐ don't know
Date of last diabetes screening: _____ Results: ☐ normal ☐ abnormal ☐ don't know
Date of last mammogram: _____ Results: ☐ normal ☐ abnormal ☐ don't know
Date of last colonoscopy: _____ Results: ☐ normal ☐ abnormal ☐ don't know