Reno Women's Health

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Name: _____ Date of Birth: _____/_____/_____

Preferred Lab: _____

Pharmacy: _____

Reason for visit: _____

Gynecology History:

Age of first menstrual period _____ Age of menopause_____

First day of last menstrual period____/_____/_____

Number of days between each period? _____

How many days does your period last? _____

Pain during periods? ○ None ○ Mild ○ Moderate ○ Severe

Menstrual Flow: ○ Light ○ Regular ○ Heavy

Gynecology Problems:

____Abnormal pap smear / high risk HPV

____Cervical Cancer

____Cervical Dysplasia

____Cryotherapy/LEEP/Cold Knife Cone

_____ Previous colposcopy

_____ Genital herpes

Current Contraception

Condoms	Ring	Menopause	
Abstinence	Depo-Provera	Bilateral tubal ligation / salpingectomy	
Pills	Paragard/Copper IUD	Hysterectomy	
Patch	Liletta/Kyleena/Mirena/Skyla IUD	Vasectomy	
Withdrawal	Nexplanon	Same gender sexual relationship	None

Pregnancy History:

Number of pregnancies: ____ Number of full-term births: _____

Number of living children: ____ Number of ectopic pregnancies _____

Number of miscarriages: ____ Number of elective terminations (medical or surgical): _____

Twin Pregnancy _____ Number of premature births (less than 37 weeks): _____

Pregnancy History Cont.

Date	GA (weeks)	Length of Labor	Birth Weight	Sex M/F	Type of Delivery	Anesthesia	Place of Delivery	Pre-Term Labor?	Complications
1.									
2.									
3.									
4.									
5.									
6.									

Prenatal Questionnaire (for prenatal patients)

Do you consent to receiving blood transfusions: ☐ Yes ☐ No

Do you have any pet cats in the home: ☐ Yes ☐ No

Do you or your current partner have history of genital herpes?

Yourself: ☐ Yes ☐ No

Your current partner: ☐ Yes ☐ No

History of STD, Gonorrhea, Chlamydia, HPV, Syphilis ☐ Yes ☐ No

Live with someone with TB or exposed to TB: ☐ Yes ☐ No

Do you or the father of the baby have a family history of genetic or chromosomal abnormalities?

☐ No ☐ Yes if yes, please explain _____

Preventative Care: When was your last:

Pap Smear: _____ Bone Density: _____

Mammogram: _____ Colonoscopy: _____

Have you had Gardasil Vaccine? ☐ Yes ☐ No ☐ Interested in information

Medical History:

- ☐ **No Medical Problems**
- ☐ **Asthma**
- ☐ **Anemia**
- ☐ **Anxiety**
- ☐ **Blood Clotting Disorder**
- ☐ **Cancer**
- ☐ **Depression**
- ☐ **Diabetes**
- ☐ **Heart Problems**
- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **Intestinal Problem**
- ☐ **Kidney Problems**
- ☐ **Liver Disease**
- ☐ **Migraines**
- ☐ **Osteoporosis**
- ☐ **Stroke**
- ☐ **Stomach Problems**
- ☐ **Thyroid Problems**
- ☐ **Covid-19**
- ☐ **Other** _____

Past Surgical History:

Date	Type of Surgery

Past Hospitalizations

Date	Reason

Allergies

Allergy	Reaction Type

Medications / Vitamins / Supplements

Name (generic / brand)	Dosage	Frequency

Do you currently?

Smoke or Vape - Yes No

If yes, number packs per day and for how many years? _____

Use Marijuana - Yes No

If yes, how much and how often? _____

Use Alcohol - Yes No

If yes, how much and how often? _____

Use Illicit Drugs- Yes No

If yes, how much and how often? _____

Family History

Do you have a family history of the following? If yes, please indicate which family member.

Blood Clots _____ Uterine Cancer _____

Diabetes _____ Ovarian Cancer _____

Heart Disease _____ Colon Cancer _____

Breast Cancer _____

Safety: Is violence at home a concern for you? ☐ Yes ☐ No

Have you ever been abused? ☐ Yes ☐ No

Domestic Violence Resource Center

(P): 775-329-4150

Crisis text line, M-F, 9 a.m. to 5 p.m. Text- DVHELP or DVSAFE to 839863

National Domestic Violence Hotline

Call 800-799-7233

Text "START" to 88788

Suicide Hotline

Call or Text 988

_____ _____

Signature of patient, parent/legal guardian, or authorized representative Date

_____

Name of patient, parent/legal guardian, or authorized representative (printed) / Relationship of patient