Connecticut Childbirth and Women's Center

Health History Form

Name _____ Date of birth _____ Age _____

Preferred pronoun: _____ Ethnicity / Race: _____

1. Social history

What is your occupation and work environment? _____

Relationship status (please circle): Single Married Separated Divorced Widowed Co-habiting Domestic partnered

2. Medication History

List any current medications and dosage (including over-the- counter and vitamins/herbs/supplements):
Are you allergic to any medications/foods/agents?

3. Menstrual history

First day of last menstrual period: _____

Age at first period: _____

Age when periods stopped, if menopausal: _____

Number of days between periods: _____

How many days do you bleed for each period? _____

Do you have any problems with your periods?

_____

_____

_____

_____

4. Sexual history

Are you currently involved in any kind of sexually activity? Y N
Current sex partner(s) is/are: Male Female Both
How long have you been sexual with your partner(s)? How many partners have you had in the past year?
Have you ever experienced sexual, verbal, or physical abuse?
Pain with sex? Problems with interest in or enjoying sex?

5. Pregnancy history

Date of Birth, Miscarriages, Terminations	Weeks Gestation	Gender	Length of labor	Place of Birth	Birth Weight	Type of Birth Vaginal or Cesarean, Complications	Breastfed	If so, when did you stop?
							Y / N	
							Y / N	
							Y / N	
							Y / N	
							Y / N	

Tell us about your breast feeding experience or difficulty with breastfeeding _____

_____

_____

Connecticut Childbirth and Women's Center

Health History Form

6. Contraceptive history

How do you avoid pregnancy? _____ Are you interested in birth control? _____

How long have you used this method? _____ Is this method working well for you? _____

Previous method(s) of birth control? _____

7. Perimenopause / Menopause history

Leaking urine? Y N When did it start? How often?
Hot flashes or night time sweats?
Pain or discomfort with urine?
Memory loss?
Have you ever taken hormone therapy?
Have you had a Bone density (Dexa) scan? Y / N When?
Have you had a colonoscopy? Y /N When?
Have you ever had a mammogram? Y /N When?
Family h/o Osteoporosis? Y / N

8. Gynecological history

Date of last Pap test: _____ Result: _____ Never had one _____

How you ever had a Colposcopy? Freezing/ Burning / LEEP of the cervix? _____

Have you ever had any of the conditions listed below?

Please circle which one:	When?
Gonorrhea	
Chlamydia	
Syphilis	
Abnormal Pap test	
Genital warts	

Please circle which one:	When?
Genital herpes	
Pelvic inflammatory disease	
Endometriosis	
Ovarian cyst	
Uterine fibroids	

9. Medical history

Have you/do you have any of the following:

	Anemia
	Asthma
	Blood clots
	Bleeding disorders
	Breast lumps/disease
	Broken bones
	Frequent UTIs

	Depression/Anxiety
	Diabetes
	Eating disorders
	Heart disease/murmur
	High blood pressure
	Kidney stones
	Liver disease

	Migraines / Headaches
	Thyroid disorders
	Cancer – type?
	Incontinence
	Other:

Connecticut Childbirth and Women's Center

Health History Form

10. Surgical history

Date	Please list below what procedure was done

11. Cigarette use: Never used ___ Past use ____ Current use _____ Total # years used _____ Interested in quitting? Y / N

12. Substance use

Have you/do you drink alcohol (beer, wine, mixed drinks)? _____ If yes, # of drinks/week - Current: _____ Past: _____

Have you/do you use any recreational drugs? _Y / N _ If yes, what and when? _____

13. Family medical history

Hypertension	Mother / Father / Siblings / Grandparents/ None
Diabetes	Mother / Father / Siblings / Grandparents/ None
Heart Disease	Mother / Father / Siblings / Grandparents/ None
Breast Cancer	Mother / Father / Siblings / Grandparents/ None
Cancer: type?	Mother / Father / Siblings / Grandparents/ None
Bleeding Disorders	Mother / Father / Siblings / Grandparents/ None
Other:	Mother / Father / Siblings / Grandparents/ None
Other:	Mother / Father / Siblings / Grandparents/ None

14. Are you pregnant? Or planning a pregnancy in the next year?

Do you have cats in your home? Are they inside or outside cats?
Chicken pox exposure? vaccine / infection / none
Special diet? i.e. vegan / vegetarian
Are you up to date on vaccines? Y /N Did you get all your childhood vaccines?
Have you traveled out of the country in past 6 months? Y N If so to where?
Have home or work place exposure to chemicals or radiation?

15. Do you or your family member have a history of any other following?

Y / N	Twins
Y / N	Genetic disorders
Y / N	Still birth
Y / N	Babies with heart defects

Y / N	Infertility
Y / N	Babies born with anomalies
	Other:

Name:_____ Date:_____

Domestic Violence Initiative Screening Questionnaire

- Your CCWC Practice group midwives are concerned about your health and safety and so we ask all women the same questions about violence at home
- This is because violence is very common and we want to improve our response to families experiencing violence

Please answer the following *CONFIDENTIAL* questions:

1.	Are you ever afraid of your partner?	YES	NO
2.	In the last year, has your partner hit, kicked, punched or otherwise hurt you?	YES	NO
3.	Have you ever been touched sexually against your will or without your consent?	YES	NO
4.	In the last year, has your partner put you down, humiliated you or tried to control what you can do?	YES	NO
5.	In the last year, has your partner threatened to hurt you?	YES	NO

If you answered *YES* to *ANY* of the above questions, please answer questions 5 and 6 now.

6.	Would you like help with any of this now?	YES	NO
7.	Would you like us to send a copy of this form to your PCP?	YES	NO

PCP Name/Address:_____

_____

_____

_____

Client Signature:

_____

For Midwife to fill in:

DV Risk Status:

Domestic Violence not identified ○
Domestic Violence identified, refused help ○
Domestic Violence identified, help provided ○

Provided With:

Contact phone numbers for DV ○
Written information for DV ○
Referral to community DV service ○
Other referral:_____

_____

_____

_____

_____

_____

_____

For Midwife to fill in:

Screening Not Completed Due to:

Presence of partner ○
Presence of family member/friend ○
Absence of interpreter ○
Woman refused to answer ○

Additional comments:_____

_____

_____

_____

_____

_____

Signature of Provider:

_____

Date:

_____

Risk Assessment Form

Patient Name:_____Date:_____

It is important that you complete this form as best as you can. Your family and personal history of disease can impact your provider's recommended plan of care today as well as in the future.

Have **you** been diagnosed with any of the following:	Age diagnosed
Breast or ovarian cancer (any age)	
Metastatic prostate cancer (cancer that spread or considered aggressive	
Colon cancer before age 65	
Uterine/endometrial cancer before age 65	
Pancreatic cancer	

For this, please consider these relatives and their ages of diagnosis: *Mother, Father, Siblings, Children, Half-siblings, Aunts/Uncles, Grandparents, Nieces/Nephews, Great Aunts/Uncles, Great Grandparents, first cousins*. Do your best to narrow down the decade of diagnosis (30's40's, 50's, OR if they were diagnosed before or after age 50).,

		Have any **family members** listed above been diagnosed with:	List family member and age diagnosed
Y	N	**Breast** cancer before **age 50**	
Y	N	**Ovarian Cancer** at any age	
Y	N	**Pancreatic** cancer at any age	
Y	N	**Male breast** cancer	
Y	N	**Metastatic prostate** cancer in a family member at any age	
Y	N	2 Breast cancers in one person (same or different breast)	
Y	N	**Colon** cancer diagnosed **before age 50**	
Y	N	Many colon polyps (at least 20 cumulative adenomas/precancerous)	
Y	N	**Uterine/endometrial** cancer diagnosed **before age 50**	
Y	N	3 or more of the following cancers at any age, same side of family: colon, rectal, uterine/endometrial, brain, gastric/stomach, kidney, renal pelvis/ureter/bladder, sebaceous adenoma, small bowel	

Office Use Only:

Does patient meet criteria for genetic evaluation (ONE YES)? _____ Yes _____N

Patient decision of genetic testing recommendation: Accepted myRisk _____Declined myRisk_____

Patient's Signature: _____Date_____