FEMALE MEDICAL HISTORY FORM **ALL INFORMATION IS CONFIDENTIAL**

Radford Student Health Service serves women of all ages and sexual orientations (lesbian, heterosexual, and bisexual). We have tried to make this form as comprehensive as possible, realizing that some questions will not be pertinent to every women's particular circumstances. If you have trouble answering any of the questions, the interviewer will be glad to help you.

Name:_____ Birth date_____/_____/_____ Age:_____
Last First Middle

Date:_____ RU Student ID#: _____

I HAVE OR HAVE HAD:	NO	YES	NOW
1. List any previous surgery.			
2. Are you allergic to any medications? List type & reaction you have, ex: nausea, etc.			
3. High blood pressure			
4. Heart disease			
5. Blood clots in my legs/lungs or family history of clotting disorder			
6. Varicose veins/circulatory problem			
7. Elevated cholesterol			
8. Thyroid disorder			
9. Diabetes or Polycystic Ovaries (PCOS)			
10. Asthma or lung diseases			
11. Liver disease, hepatitis, recent jaundice, mono			
12. Gall bladder disease			
13. Epilepsy, convulsions/seizures			
14. A skin disorder			
15. Emotional problems/depression/eating disorder			
16. Sickle Cell trait/disease, other anemia			
17. Cancer: Type			
18. Urinary problems			
19. Numbness in arms or legs			
20. Bowel/stomach/rectal problems			
21. Do you have any risk factors for HIV? For example: multiple partners, IV drug use, unprotected sex			
22. Sexually Transmitted Infections (gonorrhea, syphilis, herpes, chlamydia, warts)			
23. Stroke or paralysis			
24. Migraine Headaches			
25. Breast cysts or lumps or disease			
26. Infection in tubes, ovaries, uterus (PID)			
27. I do breast self-exams regularly			
28. Abnormal Pap smear			
29. Female or abdominal surgery?			
30. History of endometriosis			
31. History of ovarian cysts			
32. Do you drink and drive?			
33. Do you wear seat belts?			
34. Do you use bicycle or motorcycle helmets?			

FAMILY HISTORY: I have parents, brothers and/or sisters with: (check the disease and list the relative with the problem, (living or deceased) ☐Are you adopted

☐Diabetes_____ ☐High Cholesterol_____

☐Heart Attack_____ ☐Stroke_____

☐High Blood Pressure_____ ☐Cancer: type_____ _____

I have reviewed the above information with the patient_____
Health Care Provider's Signature

Your medical records will be retained for 10 years after your last visit. After that time they will be destroyed.

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