BRIDGEVIEW
Women's Health, LLC

1130 NW 22nd Ave., Suite 520, Portland, OR 97210
Office 503-274-4800 Fax 503-274-4917
www.bridgeviewwomenshealth.com

Physicians and Surgeons
Carmen M. Doom, MD, PhD
Dafna S. Lohr, MD
Carrie F. Miles, MD, MPH
Jennifer H. Murray, MD
Emily J. Rangel, MD

Nurse Practitioner
Joy A. Rothschild, WHNP-BC

Confidential Health History Questionnaire

Name: _____ **DOB**: _____

Nickname: _____ **Today's Date**: _____

Email: _____ **Preferred Language**: _____

Religion: _____ **Country of Origin**: _____

Marital Status: ___Divorced ___Dom. Partner ___Married ___Separated ___Sig. Other ___Single ___Widow ___Other

Race: ___American Indian ___Asian ___Black/African American ___Hispanic/Latino ___Native Hawaiian/Pacific Islander ___White/Caucasian ___Other ___Unknown ___Declined **Ethnicity**: ___ Hispanic/Latino ___Non-Hispanic

Employment Status: ___Full ___Part ___Self ___Unemployed ___Retired ___Military **Student**: ___Full ___Part

Women's Health History, Section I: (If you are menopausal, skip to section II)

At what age did you began having menstrual periods? _____ Are your periods painful? ____ Yes ____ No

How long is the time between 1st day of a period to 1st day of the next period? _____ days

How long do your periods last? _____ days

Do you use birth control? ____ Yes ____ No If so, what type? _____

List any other methods used in the past: _____

Are you satisfied with your current form of birth control? ____ Yes ____ No

If you have children, do you desire to have more? ____ Yes ____ No ____ Undecided

Have you had difficulty becoming pregnant? ____ Yes ____ No

Women's Health History, Section II:

Are you menopausal? ____ Yes ____ No Age of menopause? _____

Are you sexually active at this time? ____ Yes ____ No If so, with: ____ Men ____ Women ____ Both

Do you have more than one sexual partner? ____ Yes ____ No Number of sexual partners in the past year: _____

Do you have pain with sex? ____ Yes ____ No Bleeding with intercourse? ____ Yes ____ No

Name: _____ DOB: _____ Date: _____

Have you ever had Pelvic Inflammatory Disease (PID) or infection in your tubes or ovaries? ____ Yes ____ No

Would you like to be tested for sexually transmitted disease (STD)? ____ Yes ____ No

Have you ever had: ____ Genital Herpes ____ Warts ____ Chlamydia ____ Gonorrhea ____ Syphilis ____ HIV

Have you ever been tested for STDs? ____ Yes ____ No If so, what type and when? _____

If so, have you had unprotected intercourse with a new partner since last tested? ____ Yes ____ No

Have you ever been a victim of: ____ Sexual Assault ____ Physical Abuse

____ Domestic Violence (hit, kicked, pushed, threatened, in any way?) Are you currently safe? ____ Yes ____ No

Is there any aspect of your sexuality or sexual problems that you would like to discuss? ____ Yes ____ No

Have you had any of the following vaccines?

____ HPV vaccine? (Age 9-26) ____ Tdap ____ Meningococcal (MCV)

____ Zovirax (Shingles) ____ Flu ____ Pneumococcal (Pneumonia, >65)

Do you have any of the following symptoms:

Vaginal: ____ Odor ____ Burning ____ Itching ____ Bulging ____ Unusual Discharge

Urinary: ____ Pain ____ Frequency ____ Urgency ____ Leaking with cough, laugh, sneeze or exercise

____ Leaking with urgency to urinate ____ Unable to initiate stream/empty completely

Pelvic: ____ Pain ____ Pressure ____ Bloating ____ Uterus, bladder or rectum pushing down

Menopause: ____ Insomnia ____ Hot Flashes ____ Night Sweats ____ Irritability

____ Vaginal Dryness ____ Decreased Sex Drive

Bowels: ____ Hard Stools ____ Blood in Stool

Painful bowel movements? ____ Yes ____ No Frequency of bowel movements? _____

Mood: ____ Depression ____ Anxiety ____ Mania ____ Panic Disorder

Do you currently have thoughts of harming yourself or others? ____ Yes ____ No

When was your last Pap smear? _____ Was it abnormal? ____ Yes ____ No

If yes, please list the year, abnormal result and the follow-up treatment: _____

_____

When and where was your last:

Cholesterol Check: _____ Normal or Elevated? _____

Mammogram: _____

Colonoscopy: _____

Bone Density Study (DEXA Scan): _____

Name: _____ DOB: _____ Date: _____

Do you have any allergies? _____

Past/Present Illnesses: (circle all that apply) **Date Diagnosed/Details**:

Diabetes: Type I Type II _____
Headaches: Tension Migraine Unsure _____
Heart Attack or Stroke _____
High Blood Pressure (Hypertension) _____
High Cholesterol or Triglycerides _____
Depression Anxiety Bipolar Disorder _____
Anorexia, Bulimia or other eating disorder _____
Hypothyroidism Hyperthyroidism _____
Cancer: Type_____ _____
Asthma or other Lung Disease _____
Recurrent Bladder and/or Kidney Infections _____
HIV Hepatitis B Hepatitis C _____
Bleeding or Clotting Disorder _____
History of Blood Transfusions _____
Pulmonary Embolism, Deep Vein Thrombosis _____
(blood clot in arms, legs or lungs)

Please list any other medical problems, along with details: _____

_____

Previous Hospitalizations, Surgeries or Serious Injuries:

Type/Details	Year
_____	_____
_____	_____
_____	_____

Personal Habits:

How many times per week do you exercise? _____ What type? _____

Do you smoke/use: ____ Cigarettes ____ eCigarettes/Vapor ____ Marijuana (any form) ____ Smokeless Tobacco

If so, how much/many per day? _____ How long? _____

If you quit smoking, please list when: _____

Do you drink alcohol? ____ Yes ____ No If so, how many drinks per week? _____

If you quit drinking, please list when: _____

Do you drink caffeine? ____ Yes ____ No If so, how much per day? _____

Have you ever used: ____ Cocaine ____ Heroin/Narcotics ____ Methamphetamines ____ Ecstasy

If so, please list when and how much: _____

Please list any specific questions you wish to discuss with the Doctor: _____

_____

Name: _____ DOB: _____ Date: _____

Pregnancy History:

How many times have you been pregnant? _____ Number of living children: _____

Do you have any adopted children? ____ Yes ____ No How many? _____

Do you have step-children? ____ Yes ____ No How many? _____

Have you ever had a miscarriage? ____ Yes ____ No Dates: _____

If so, was a D&C required? ____ Yes ____ No Were there any complications? ____ Yes ____ No

Have you ever had an ectopic (tubal) pregnancy? ____ Yes ____ No When? _____

If so, were you treated with medication or surgery? _____ Type? _____

Were there any complications? ____ Yes ____ No If so, type? _____

Have you ever had an abortion? ____ Yes ____ No When? _____

If so, was it medical or surgical? _____ Were there any complications? ____ Yes ____ No

Previous Births:

Date	Vaginal or Cesarean	Sex	Name	Weight	Complications
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Family History – Past/Present Illnesses:

Disease/Condition	Relation	Maternal/ Paternal	Details
Diabetes: Type I Type II	_____	_____	_____
Heart Disease or Attack	_____	_____	_____
High Blood Pressure	_____	_____	_____
High Cholesterol/Triglycerides	_____	_____	_____
Hypo/Hyperthyroidism	_____	_____	_____
Breast Cancer	_____	_____	_____
Uterine Cancer	_____	_____	_____
Ovarian Cancer	_____	_____	_____
Other Cancer(s)	_____	_____	_____
Osteoporosis or Hip Fracture	_____	_____	_____
Depression or Substance Abuse	_____	_____	_____
Bleeding or Clotting Disorder	_____	_____	_____
Pulmonary Embolism, Deep Vein Thrombosis (blood clot in arms, legs or lungs)	_____	_____	_____

If born between 1938 – 1971, did your mother take DES while she was pregnant with you? ____ Yes ____ No