VANDERBILT UNIVERSITY
MEDICAL CENTER

NAME:
DOB: / /
DATE: / /
MRN:

Vanderbilt School of Nursing Faculty Practice Primary Care for Women

West End Women's Health and Melrose

Patient Health History

Name ______________________ Race/Ethnicity: ______________________

Preferred Name ______________________ Preferred Pronouns: She/her He/Him They/them/

Date of Birth: ______________ Height: ______________ Weight: ______________

Phone number: ______________ Email address: ______________________

Preferred Pharmacy (Name, address): ______________________________

Medication allergies: ______________________________

Other allergies: ______________________________

Current medications (include non-prescription medications, supplements, vitamins, and birth control):

____

____

____

How did you hear about our practice?

____

Social History

Relationship status: ☐ single ☐ married ☐ divorced/separated ☐ widowed ☐ partnered ☐ other

Who lives with you? ______________________________

Occupation and Employer______________________________

What is the highest level of education you have completed? ______________________

Did you have any special educational needs while in school? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how much? ______________Are you interested in quitting? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No If yes, when did you start and stop (month/year)? ______________

Do you drink alcohol? ☐ Yes ☐ No If yes, how much and how often? ______________

Do you drink caffeine? (coffee, tea, soda) ☐ Yes ☐ No If yes, how much and how often? ______________

Do you currently use any recreational drugs? ☐ Yes ☐ No If yes, what drugs? ______________

Have you used recreational drugs in the past? ☐ Yes ☐ No If yes, what drugs? ______________

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Health Maintenance

Do you regularly exercise? ☐ Yes ☐ No If yes, how often? ___________Type of exercise? ___________________

Do you follow a special diet? ☐ No ☐ Vegetarian ☐ Vegan ☐ Other _________________________________

Do you have: ☐ unexplained weight loss or gain? ☐ weight concerns? ☐ current/past disordered eating?

Immunizations (check if current/immune) ☐ Tetanus/pertussis ☐ Chicken pox ☐ Rubella ☐ Influenza

☐ Shingles ☐ Pneumonia ☐ HPV (Gardasil)

Do you have an advanced directive/ living will? ☐ Yes ☐ No Would you like information about this? ☐ Yes ☐ No

Do you wear a seat belt? ☐ Yes ☐ No Do you use sunscreen? ☐ Yes ☐ No

Reproductive History

1st day of last menstrual period: ______________, or ☐ post-menopausal ☐ post-hysterectomy ☐
hormonal suppression (= no menses due to breastfeeding, birth control pills, Depo-Provera, IUD, etc.)

Age at first menstrual period: _______ Frequency: every _________ days Periods are: ☐ regular ☐ irregular

Discomfort: ☐ None ☐ minimum ☐ moderate ☐ severe Recent changes? Please describe: ________________

Number of: Total pregnancies: _______ Pregnancy losses/ terminations:________ Living children:___________

Are you currently sexually active? ☐ Yes ☐ No If yes, ☐ with men ☐ with women ☐ with both

Do you use any method to prevent pregnancy? Yes No N/A

If so, please list: ____

Do you desire STI testing today? ☐ Yes ☐ No

Have you ever been treated for an STI? ☐ Yes ☐ No If yes, which? __________________ When? __________

When was your last Pap smear? _________________

Do you have history of abnormal Pap smears? ☐ Yes ☐ No If yes, when?____________Treatment? ___________

When was your last: Mammogram? ___________ Colonoscopy? _____________ Bone density scan? ___________

Eye Exam? _____________? Dental Cleaning/Exam? _________________

Because abuse is an enormous problem among women, we ask all of our patients about a history of or present abuse so we may best meet your needs as your care provider.

Have you ever experienced violence or abuse? ☐ Yes ☐ No ☐ I'm not sure. ☐ I prefer not to answer.

If yes, please check all that apply: ☐ Emotional ☐ Physical ☐ Sexual ☐ Verbal ☐ Spiritual ☐ Other: __________

☐ I would like to discuss this in more detail. ☐ I do not wish to talk about this during my visit today.

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Personal Medical History

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer (type: ________________)
- ☐ Ulcerative Colitis
- ☐ Crohn's disease
- ☐ COPD
- ☐ Diabetes
- ☐ Gestational Diabetes
- ☐ Lupus
- ☐ Epilepsy (seizures)
- ☐ Endometriosis
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ Hypothyroidism (under active)
- ☐ Hyperthyroidism (over active)
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Migraines
- ☐ Anxiety
- ☐ Depression
- ☐ HIV/AIDS
- ☐ Uterine fibroids
- ☐ Irritable Bowel Syndrome
- ☐ Allergies
- ☐ Sleep apnea
- ☐ GERD/Acid Reflux
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Pulmonary embolism
- ☐ Stomach or peptic ulcer
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Preeclampsia

Please list past surgeries or hospitalizations and dates ____

____

Family Medical History

*Please check the boxes below as they apply. Indicate family member(s) and side of family (i.e. maternal **M**, paternal **P**) with this history on the line that follows.*

- ☐ Bipolar disorder ______________
- ☐ Breast Cancer : ______________
- ☐ Colon Cancer : ______________
- ☐ Ovarian Cancer : ______________
- ☐ Other Cancer : ______________
- ☐ Osteoporosis : ______________
- ☐ Crohn's disease ______________
- ☐ Celiac disease ______________
- ☐ Alzheimers, other dementia ______________
- ☐ Addiction (alcohol, drugs) ______________
- ☐ Depression ______________
- ☐ Diabetes, type1 or 2 (circle) ______________
- ☐ Heart disease ______________
- ☐ Hypo or Hyperthyroidism (circle) ______________
- ☐ Parkinson's : ______________
- ☐ High Blood Pressure ______________
- ☐ Blood Clotting Disorder ______________
- ☐ Kidney disease ______________
- ☐ Schizophrenia ______________
- ☐ Stroke ______________
- ☐ Heart Attack ______________
- ☐ Blood Clot ______________
- ☐ Cystic Fibrosis ______________
- ☐ Genetic Disorder ______________
- ☐ Other ______________

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Do you have a family history of breast, colon, or uterine cancer?

Relationship ______________________________ Age at diagnosis ________________

Do you have a family history of heart attacks or stroke before the age of 55?

Relationship ______________________________ Age at diagnosis ________________

Mood

PHQ-2 - Mood interview:

Over the last 2 weeks, how often have you been bothered by the following problems?

0=not at all 1= several days 2= more than half the days 3=nearly every day

Little interest or pleasure in doing things	0	1	2	3
Feeling down, sad, or hopeless	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you answered positively above, how difficult have these issues made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

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PHQ-7

Additional Mood interview – to be completed ONLY if you answered 1, 2 or 3 to any of the previous three questions:

Over the last 2 weeks, how often have you been bothered by the following problems?

0=not at all 1= several days 2= more than half the days 3=nearly every day

Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3