mississippi health center
4631 N. Albina
Portland, OR 97217
(503) 282-5358

WOMEN'S HEALTH HISTORY

Name: _____ Date: ___/____/____

1. Date of last pelvic exam/PAP:_____ Results:_____
   Any past positive PAP?_____
2. OB history: # of pregnancies_____ Date/Type (vag or cesarean) of deliveries_____
3. Please list any pelvic or abdominal surgeries _____
   _____
4. Please list types of birth control/ length of time utilized _____
   _____

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5. If you have now, or had in the past, any of the following, please check and explain with dates:

___ low back pain _____
___ menstrual pain _____
___ PMS _____
___ pain during sex _____
___ fibroids/cyst _____
___ hemorrhoids _____
___ tearing with birth _____
___ sexual abuse _____
___ depression _____
___ drug abuse _____
___ eating disorder _____
___ pelvic/abdom pain _____
___ prolonged bleeding/altered cycles_____
___ Irritable bowel _____
___ sexually transmitted disease _____
___ UTI/bladder infections _____
___ constipation _____
___ childbirth complications_____
___ physical or other abuse _____
___ cancer _____
___ smoking habit _____
___ weight issues _____

6. Please write any other pertinent information here: _____
   _____