Name: Date of Birth: Date:

Reason for visit: _____

Medical History Have you ever had any of the following?

__ Abnormal Pap
__ Anemia
__ Anxiety
__ Arthritis
__ Bladder/Kidney Infections
__ Blood Clots in Lung/Legs
__ Blood Transfusion
__ Cancer What type?_____
_____
__ Depression
__ Diabetes
__ Drug/Alcohol Problem
__ Endometriosis
__ Epilepsy/Seizures
__ Fibroids
__ Fibromyalgia
__ Heart Disease/Attack
__ High Blood Pressure
__ High Cholesterol
__ Liver Disease/Hepatitis
__ Sickle Cell Disease
__ Stroke
__ Hyperthyroid
__ Hypothyroid
__ Other _____
_____

Have you ever had any of the following STD's? ____ Chlamydia __ HPV __ HIV __ None
____ Gonorrhea __ Syphilis __ Hepatitis B
____ Herpes __ Trichomonas __ Hepatitis C

Date of last Pap smear _____ ____ Normal __ Abnormal

Have you needed any of the following for an abnormal pap? __ **Colposcopy** __ **None**
____ **Cryosurgery** __ **Leep/Laser/ Conization**

mm/yy of last Mammogram_____ ____ Normal __ Abnormal __ Never
mm/yy of last Bone Density_____ ____ Normal __Osteopenia __Osteoporosis __Never had one
mm/yy of last Colonoscopy_____ ____ Never had one
mm/yy of last Cholesterol test_____ ____ Never had one mm/yy of last Thyroid Test_____

Surgical History Please list all surgeries with dates:

_____ _____
_____ _____

List all medications you are currently taking, including over-the-counter medications, vitamins and herbal remedies:

_____ _____ _____ _____
_____ _____ _____ _____

List any allergies to medications: _____ __ No Known Allergies

LATEX Allergy? _____Yes _____No

Family History Use these Abbreviations: **M**/Mother **F**/Father **MGM**/Maternal Grandmother **A**/Aunt **PGM/**Paternal Grandmother **MGF**/Maternal Grandfather **PGF**/Paternal Grandfather **U**/Uncle **S**/Sister **B**/Brother

	Relative / Age at Diagnosis		**Relative**
__ Breast cancer		__ High Blood Pressure	
__ Ovarian cancer		__ Diabetes	
__ Uterine cancer		__ Heart Disease (heart attack,	
__ Colon cancer		stroke, bypass surgery)	

Obstetrical History

Total number of Pregnancies _____ # of Living Children_____

IF YOU ARE 50 OR OLDER, YOU DO NOT NEED TO LIST PREGNANCIES BELOW

Please list all pregnancies in order, including miscarriages, premature birth, stillbirths, ectopic (tubal), and abortions:

MM/DD/ YYYY	M/F	Type of Delivery	Length of Pregnancy	Length of Labor	Birth Weight	Hospital

GYN History

Age of first period _____
Date of last period _____ **(Start Date)**
Cycle length: every _____ days
How long do they last _____ days

Periods are: ____ Regular ____ Irregular ____ Painful ____ Not bothersome ___ Any Clots? ___small ___medium ___large

Flow is: __ Light __ Light to moderate __ Moderate to Heavy __ Very Heavy

Are you sexually active? __ Yes __ No

Sexual preference __ Male __ Female __ Both

New Partners? __ Yes __ No

Number of lifetime partners: _____

Method of Birth Control: __ Condoms __ Pills __ Patch __ Depo Provera ____ Implanon ____ Vaginal ring ____ Tubal Ligation IUD __ Partner with Vasectomy __ Natural Family Planning __ Other _____ __ None

Social History

Alcohol use	__ Yes	__ No	If yes,_____drink(s) per day/week/month		
Tobacco use	__ Yes	__ No	If yes,_____pack(s) per day for ____years		
Street drug use	__ Yes	__ No	Type and frequency_____		
Caffeine	__ Yes	__ No	If yes,_____caffeinated drinks per day		
Sexual Abuse	__ Yes	__ No	If yes, are you safe now?	__ Yes	__ No
			Counseling?	__ Yes	__ No
Physical Abuse	__ Yes	__ No	If yes, are you safe now?	__ Yes	__ No
			Counseling?	__ Yes	__ No
Emotional Abuse	__ Yes	__ No	If yes, are you safe now?	__ Yes	__ No
			Counseling?	__ Yes	__ No

Exercise __ Sedentary __ Minimal amount __ Moderate amount __ Heavy amount __ Active, but no formal exercise

Have you had exposure to hazardous materials: ____ Yes __ No

Do you wear a seat belt? __ Yes __ No

Are you employed? __ Yes __ No If yes, describe type of job duties _____

__ Trade __ Skilled __ Professional

Education __ Current student __ Did not complete or attend

High School (Number of years)_____ GED_____

__ College, __2 year __4 year __ Graduate studies __ Post Grad studies __ Unknown

Military Status Have you ever served?___ Active:___ Retired: ___

Review of Systems Have you had any of these in the past month?

General Health: __ Body Aches

Eyes: __ Impaired Vision

HENT: __ Headaches

Breasts: __ Lumps __Tenderness __ Nipple Discharge

Cardiovascular: __ Chest pain

Respiratory: __ Shortness of Breath

Gastrointestinal: __ Constipation __ Blood in Stools __ Hemorrhoids

Musculoskeletal: __ Joint Pain

Psychiatric: __ Anxiety __Depression

Urinary: __ Urgency __Frequency __ Pain with Urination __ Leaking __Irregular Menses __ Heavy Periods __Vaginal Discharge