NAME: **DATE:**

REASON FOR VISIT

PAST MEDICAL & FAMLY HISTORY

PLEASE CHECK (3) IF YOU (PERS) OR ANY BLOOD RELATIVE (FAM) HAD ANY OF THE FOLLOWING CONDITIONS

	PERS	FAM		PERS	FAM
1. WT LOSS-GAIN	☐		15. BLOOD TRANSFUSIONS	☐	
2. HEADACHES/MIGRAINE	☐		16. ANEMIA/BLOOD DISORDER	☐	
3. HEART ☐ VALVULAR DIS ☐ DISEASE RHEUMATIC DIS ☐	☐	☐	17. VARICOSE VEINS/PHLEBITIS	☐	
			18. SKIN DISEASE	☐	☐
4. HIGH BLOOD PRESSURE	☐	☐	19. DIABETES	☐	☐
5. HIGH CHOLESTEROL	☐	☐	20. THYROID DISEASE	☐	☐
6. RESPIRATORY DISEASE PULMONARY (LUNG)	☐	☐	21. CANCER (TYPE)	☐	☐
			22. EPILEPSY/NEUROLOGICAL DIS.	☐	☐
7. BREAST DISEASE	☐	☐	23. ARTHRITIS-JOINT PAIN	☐	☐
8. JAUNDICE / HEPATITIS	☐	☐	24. OSTEOPOROSIS (FRAGILE BONES)	☐	☐
9. HIATAL HERNIA (REFLUX)	☐	☐	25. ANXIETY/DEPRESSION	☐	☐
10. PEPTIC ULCER (STOMACH)	☐	☐	26. SLEEP PROBLEMS	☐	☐
11. BOWEL DISEASE	☐	☐	27. ENDOMETRIOSIS	☐	☐
12. KIDNEY DISEASE	☐	☐	28. FIBROIDS	☐	☐
13. URINARY INCONTINENCE	☐	☐	29. INFERTILITY	☐	☐
14. URINARY INFECTIONS	☐	☐			

SURGERIES, HOSPITALIZATIONS, OR GYNECOLOGIC PROCEEDURES (EXCLUDING PREGNANCIES)

YEAR	REASON FOR ADMISSION / HOSPITAL	YEAR	REASON FOR ADMISSION / HOSPITAL

MEDICATIONS

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (DOSAGE-FREQUENCY) - INCLUDE OVER THE COUNTER DRUGS, VITAMINS & HERBS

DRUG ALLERGIES

MENSTRAL HISTORY

AGE AT FIRST PERIOD? IF MENSTRATING - 1ST DAY OF LAST PERIOD

NUMBER OF DAYS BETWEEN PERIODS

How many days does period last?

CRAMPS? Y ☐ MILD ☐ SEVERE N ☐ MOD. ☐ ALWAYS PRESENT

MEDICATION FOR CRAMPS Y_____ N_____

HOW MANY PERIODS IN THE LAST YEAR? BLEEDING (SPOTTING) BETWEEN PERIODS? Y N

VAGINAL INFECTIONS

☐ YEAST ☐ TRICHOMONAS ☐ BACTERIAL VAGINOSIS ☐ CHLAMYDIA ☐ GONORRHEA ☐ HERPES ☐ Oral ☐ Genital ☐ HPV

PAP TEST

DATE OF LAST TEST ☐ NORMAL ☐ ABNORMAL PREVIOUS ABNORMAL PAPS AND/OR PROCEEDURES

MAMMOGRAM

DATE OF LAST TEST ☐ NORMAL ☐ ABNORMAL

SEXUAL HISTORY

AGE OF 1ST SEX (that you consented to)_____ EVER RAPED? (incl. date rape) Y N EVER MOLESTED? Y N

TOTAL NUMBER OF SEX PARTNERS MALE _____ FEMALE _____

RATE CURRENT SEXUAL ENCOUNTERS ☐ SATISFACTORY ☐ UNCOMFORTABLE ☐ WISH TO DISCUSS

CONTRACEPTIVE HISTORY

CURRENT METHOD IF PILL - BRAND PAST METHODS

OBSTETRICAL HISTORY

Number of PREGNANCIES_____ PREMATURE BIRTHS _____ MISCARRIAGES _____ ABORTIONS _____ LIVE BIRTHS _____

BORN YEAR/MO.	WEEKS PREG.	WT	SEX	TYPE OF DELIVERY	REMARKS	BORN YEAR/MO.	WEEKS PREG.	WT	SEX	TYPE OF DELIVERY	REMARKS
1.						4.					
2.						5.					
3.						6.					

MENOPAUSAL HISTORY

Approximate age of last menses _____ HOT FLASHES Y N TREATMENT -

SOCIAL HISTORY

SMOKING - Cig/ Day	# YEARS	ALCOHOL Drinks/ Wk	CAFFEINE Drinks/ Day	RECREATIONAL DRUGS	EXERCISE Days/Wk