

PATIENT INFORMATION

NAME: _____

DOB: _____

TODAY'S DATE: _____

Reason for today's visit:

Reproductive History

Last Menstrual period _____ Age of first menstrual period _____ Age of menopause _____ Hormones Y N
 Menstrual frequency _____ How many days of bleeding _____ Tampons or pads _____
 Abnormal bleeding Y N Pain with periods Y N Fibroids Y N Ovarian cysts Y N
 Sexually active Y N Age at first intercourse _____ # of partners _____ Pain with intercourse Y N
 Birth Control Y N Birth control method: condoms pills Nuvaring IUD sterilization Depo
 History of sexually transmitted diseases Y N History of sexual or physical abuse Y N
 Do you know how to perform breast self exams Y N
 Date of last pap smear _____ Results _____ History of abnormal paps _____
 Date of last mammogram _____ Results _____ History of abnormal mammograms _____

Obstetric History (Please list all pregnancies, including miscarriages, ectopic pregnancies or elective terminations)

#pregnancies	#full term	#preterm	#ectopics	#miscarriages	#elective terminations	#multiples	#living
_____	_____	_____	_____	_____	_____	_____	_____
Date	Weight	Vaginal/C-Section	Preterm Labor	Male/Female	Complications		
_____	_____	_____	_____	_____	_____		
_____	_____	_____	_____	_____	_____		
_____	_____	_____	_____	_____	_____		

Medications (Prescription and over the counter)

Drug Name	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Has anyone ever had:	Family member (maternal/paternal)	Age at onset
Breast cancer Y N	_____	_____
Ovarian cancer Y N	_____	_____
Colon cancer Y N	_____	_____
Uterus cancer Y N	_____	_____
Cervical cancer Y N	_____	_____
Heart disease Y N	_____	_____
Hypertension Y N	_____	_____
Stroke Y N	_____	_____
Diabetes Y N	_____	_____

Allergies

Latex Y N
 Seasonal Y N

Medications (please list medication and reaction):

Surgical History

Other surgeries	Date	Reason
Hysterectomy Y N	_____	Abdominal, vaginal, laparoscopic?
Ovaries removed Y N	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History

Arthritis Y N
 Hypertension Y N
 Stroke Y N
 Hypercholesteremia Y N
 Thyroid disease Y N
 Autoimmune disease Y N
 Blood disorders Y N
 Osteoporosis Y N
 Cancer Y N
 Diabetes Y N

Social History

Relationship status: Single _____ Married _____ Divorced _____ Widowed _____
 Alcohol use: Never _____ Drinks/week _____ OR Drinks/month _____
 Tobacco use: Never used _____ Current packs/day _____ Previously used _____
 Drug use: Never _____ Type/Frequency _____
 Exercise: Y N Type _____ Frequency _____