Contemporary Women's Care P.A.

Name: _____ Date of Visit:_____Date of Birth: _____

Obstetrical History: Please list <u>all</u> pregnancies including miscarriages and abortions.

Date	Route (Vag or C/S)	Sex	Delivery - # Weeks Before/After Due Date	Wt.	Complications

Date	# of Weeks	Miscarriage or Abortion	D & C Required	Complications

Gynecological History:

First day of last period: _____ Age at first period: _____ Length of period: _____
How many days from start of one period to start of next period? _____
Flow: Light _____ Medium _____ Heavy _____
Do you pass clots of blood? Yes _____ No _____ If yes, how large? _____
Cramps? No _____ Mild _____ Moderate _____ Severe _____
Relieved by medication? Yes _____ No _____
What method are you currently using to prevent pregnancy? _____

Have you had?	No	Yes	When
Gonorrhea			
Chlamydia			
Syphilis			
Genital Warts			
Trichomonas			
Herpes			
Hepatitis B			
HIV			

Date of last Pap: _____ Results: _____
Have you ever had an abnormal pap? Yes _____ No _____ Unsure _____
If yes, when? _____ Results _____ Treatment Required _____
Date of last Mammogram: _____ Results: _____
Date of last Colonoscopy: _____ Results: _____
Date of last DEXA (bone density) scan: _____ Results: _____

Previous Medical History:

Do you have:	No	Yes	Date of Diagnosis	Treatment
Hypertension				
Diabetes				
Thyroid Disease				
Anemia				
Vitamin D Deficiency				
High Cholesterol				
High Triglycerides				
Heart Disease				
Breast Cancer				
Other Cancer				
Depression/anxiety				
Asthma				
Migraines				
PCOS				
Seasonal allergies				
Osteoporosis				
Other: _____				

Previous Surgical History: Please list each surgery you have had.

Date	Type	Reason	Surgeon	Complications

Hospitalizations – Other than surgeries and deliveries:

Date	Reason	Physician

List all medications that you are taking regularly: Please include over the counter meds, vitamins, herbs, and supplements.

Medication	Dose	Reason	Prescribed by

List any allergies to medications:

Medication	Reaction

Family History: Please list family members with medical problems.

	Illnesses	Living/Deceased	Age at Death	Cause of Death
Father				
Mother				
Siblings				
_____				
_____				

Do you have any family history of breast, ovarian, or colon cancer?
No _____ Yes _____ If yes, please list above.

Marital Status: _____ Sexual Orientation: _____ Occupation: _____
Persons living with you: _____
Do you wear seatbelts? No ___ Yes ___
Do you have an exercise program? No ___ Yes ___ Type _____ Times/week _____
Do you follow a specific diet? No ____ Yes _____ Type _____
How many servings of dairy do you eat per day? _____ (8 oz milk, 1 oz cheese, 6 oz yogurt)
Do you smoke now? No ____ Yes ____ PPD _____ For _____ years
Have you smoked in the past? No ____ Yes ____ PPD _____ For _____ years
When did you stop? _____

How many alcoholic drinks do you have each day? _____ Week _____ Month _____

Do you use: Marijuana ____ Cocaine ____ Heroin ____ Methamphetamines ____ IV Drugs _____
Other _____

Do you perform monthly self breast exams?	Yes _____	No _____
Have you been immunized for Hepatitis B?	Yes _____	No _____
Have you been immunized for HPV (Gardasil)?	Yes _____	No _____
Have you had chicken pox/Varicella vaccination?	Yes _____	No _____

Date of last Tetanus booster: _____
Date of last flu shot: