# MERIDIAN PRIMARY CARE

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Patient's Name:______________________________DOB: __________ Date: ___________

Medications: _________________________________________________________________

***Please answer the following questions so that we may better serve your health needs.***

Your Age: ________ Allergies: _______________________________________

If you have ever been pregnant, please indicate the number of the follow:

Pregnancies _____ Full-term live births _____ Premature live births _____

Abortions _____ Miscarriages _____ Living children _____

Age when you had your first menstrual period:________________

When was your last mammogram (x-ray of your breasts): _________ ____________________

When was the FIRST day of your most recent period: _________________________________

If menopausal, have you had a hysterectomy? [ ] Yes [ ] No

Do you have any bothersome menopausal symptoms? __________________________________________

Are you on hormone replacement therapy? [ ] Yes [ ] No

When was your last PAP smear? [ ] Never [ ] 1 yr ago [ ] 2 yr [ ] ≥ 3 yr

Were the results normal? [ ] Yes [ ] No

Have you ever had an abnormal PAP test? [ ] Yes [ ] No

If yes, did you have further evaluation (e.g. colpo, biopsy, rePAP, etc.): ____________________________

How often do you usually get your period? Every ________ days or [ ] No periods

Are your periods regular? [ ] Yes [ ] No How long do they last? ______days

The blood flow is generally: [ ] Light [ ]Moderate [ ] Heavy

Do you have vaginal bleeding between periods? [ ] Yes [ ] No

If menopausal, have you ever started bleeding again? [ ] Yes [ ] No

Do you have any vaginal discharge that is different from your usual? [ ] Yes [ ] No

Are you sexually active? [ ] Yes [ ] No

Do you and your partner(s) use some form of birth control? [ ] Yes [ ] No

Method: __________________________________

Do you and your partner(s) use some form of STD protection? [ ] Yes [ ] No

Method: __________________________________

Have you ever had a sexual transmitted disease (STD)? [ ] Yes [ ] No

Have you ever used fertility drugs? [ ] Yes [ ] No

Has your mother ever taken a hormone called DES (diethylstilbestrol)? [ ] Yes [ ] No

Do you smoke? [ ] Yes [ ] No How much per day? _________________________

How often do you perform self breast exams? [ ] Never or Other:_________________________

Has anyone ever abused or hurt you, either physically or verbally: [ ] Yes [ ] No

Do you feel safe?: [ ] Yes [ ] No

Do you have any family history of:

Breast Cancer: [ ] Yes [ ] No Family member: ____________________________

Colon Cancer: [ ] Yes [ ] No Family member: ____________________________

Uterine Cancer: [ ] Yes [ ] No Family member: ____________________________

Ovarian Cancer: [ ] Yes [ ] No Family member: ____________________________

Other Cancers: [ ] Yes [ ] No Family member & type: ______________________

Heart Disease: [ ] Yes [ ] No Family member: ____________________________

On a scale of 1 to 10 (10 being the most severe) how would you rate your:

Premenstrual symptoms: 0 1 2 3 4 5 6 7 8 9 10

Pain during sex: 0 1 2 3 4 5 6 7 8 9 10

Pain during your usual period: 0 1 2 3 4 5 6 7 8 9 10

Please list any other concerns: ______________________________________________