REPRODUCTIVE HISTORY

(INCLUDE ALL MISCARRIAGES, ABORTIONS, AND ECTOPIC PREGNANCIES)

Check here if never pregnant: ☐

	Date of delivery	Term/ preterm	Vaginal or cesarian	Hours of labor	Weight	Hospital/ city
example:	**1988**	**40 weeks**	**vaginal**	**15 hours**	**6 lbs.**	**St. Luke's**

Please describe any problems you have had with your pregnancies and tell us what happened:

_____

_____

GYNECOLOGIC HISTORY

How old were you when you had your first period? _____ Date of last menstrual period? _____

Do you still menstruate?

☐ **Yes**, regularly (every 25-35 days) ☐ **Yes**, but not regularly

How many days are there between periods? _____ *How many days do your periods last?*_____

☐ **No**, I no longer menstruate because of:

☐ Natural menopause ☐ Hysterectomy ☐ Other ☐ Don't know

Date of your last pap test: _____ Result: ☐ Normal ☐ Abnormal

Have you ever had an abnormal pap test? ☐ Yes ☐ No If yes, what was done?_____

Date of your last breast examination_____

What is your current method of birth control?

☐ I am not sexually active ☐ Oral contraceptives ☐ Rhythm ☐ Depo-Provera

☐ Only female partners ☐ Post-menopausal ☐ Foam/jelly ☐ Tubal ligation

☐ Vasectomy ☐ No birth control ☐ Condoms ☐ IUD ☐ Diaphragm

Have you ever had any of the following sexually transmitted diseases?

☐ Chlamydia ☐ Syphilis ☐ Herpes ☐ PID/pelvic infection

☐ Gonorrhea ☐ Trichomonas ☐ Warts ☐ HIV ☐ None

Did you have sexual intercourse before you were 16 years old? ☐ Yes ☐ No

Have you had more than 5 male sexual partners in your lifetime? ☐ Yes ☐ No

In the past year, have you had sex with a new male partner without using a condom? ☐ Yes ☐ No

Please check this box if there are issues associated with sexuality that you would like to discuss today: ☐

Do you think you have a vaginal infection? ☐ YES ☐ NO

Do you think you have a vaginal odor? ☐ YES ☐ NO

Do you have excessive vaginal discharge? ☐ YES ☐ NO

If YES, what color is the discharge? _____

FAMILY HISTORY

Has anyone in your immediate or extended family had:

Yes	No		If yes, WHO and AGE at the time of diagnosis:
☐	☐	Breast cancer	_____
☐	☐	Ovarian cancer	_____
☐	☐	Colon cancer	_____
☐	☐	Other cancers	_____
☐	☐	Diabetes	_____
☐	☐	Heart disease	_____
☐	☐	High blood pressure	_____
☐	☐	Drinking problem	_____
☐	☐	Other illnesses	_____

IMMUNIZATIONS

Measles/mumps/rubella vaccination dates: 1st:_____ 2nd:_____ Born prior to 1957:_____
Have you had chicken pox (varicella)? ☐ Yes ☐ No ☐ Don't know ☐ I've had the vaccine
When was your last tetanus/diphtheria shot? _____
Have you ever had an influenza vaccination (flu shot)? ☐ Yes, date _____ ☐ No
Have you ever had a pneumonia vaccination? ☐ Yes, date _____ ☐ No
List other immunizations you have had:_____
Hepatitis B vaccinations: 1st _____ 2nd _____ 3rd _____

LIFESTYLE AND HEALTH

What is your current occupation? _____
Where and with whom do you live?_____
Do you have trouble taking care of your daily activities (buying food, transportation)? ☐ Yes ☐ No
Are you under any particular stresses? ☐ Yes ☐ No _____
Do you currently smoke cigarettes? ☐ Yes ☐ No # smoked per day: _____ Year you started:____
How often do you drink alcohol?
☐ Never ☐ Monthly or less ☐ 2-4 times/month ☐ 2-4 times/week ☐ 4 or more times/week
How many drinks a day do you have when you do drink?
☐ I don't drink ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7 or more drinks
How often in the last year have you had 4 or more drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
How many drinks does it take before you begin to feel the first effects of alcohol?
☐ 1 drink or less ☐ 2 drinks ☐ 3 drinks ☐ 4 drinks ☐ 5 drinks or more
In the last year, have you used any illegal drugs (marijuana, meth, cocaine, heroin)? ☐ Yes ☐ No
At any time has a partner ever hit you, kicked you, or otherwise physically hurt you? ☐ Yes ☐ No
Are you ever afraid of your partner? ☐ Yes ☐ No
Have you ever been physically or sexually abused? ☐ Yes ☐ No
Would you like any written information on a health-related topic? _____

Patient signature:_____ Date:_____

Office use only:
Form filled out by: ☐ Patient ☐ Office Nurse ☐ ARNP/MD
Date reviewed by ARNP/MD with patient: _____
ARNP/MD signature: _____