ALL AREAS MUST BE FILLED OUT COMPLETELY

Today's Date ______/______/_______ Patient's Name ____

DOB ______/______/_______ Age ___________ Marital Status ____________________ Referring MD ________________________

Primary Care Physician ___________________________ Date last seen by PCP ________________________________

Are you fasting today (nothing to eat or drink except water for past 8 hours) □ Yes □ No

Reason for the visit:

____

____

Medical History

Were **YOU** ever diagnosed with any of the following? Please check if yes:

□ Bleeding Disorders	□ Breast Cancer	□ High Blood Pressure	□ Cancer-Other
□ Hypothyroidism	□ Cervical Cancer	□ Arrhythmias	□ Polycystic Ovary Syndrome
□ Depression	□ Ovarian Cancer	□ Heart Murmur	□ Hepatitis
□ Asthma	□ Uterine Cancer	□ Diabetes	□ HPV
□ DVT/Pulmonary Embolism	□ Gestational Diabetes	□ HIV / AIDS	□ STD
□ Post-partum Depression	□ Infertility	□ Anesthesia Complication	□ History of Chickenpox
□ Anxiety	□ High Cholesterol	□ Stroke	□ Heart Problems
□ Thyroid Problems	□ Gastrointestinal Issues	□ Migraines	□ Anemia
□ Seizures/Epilepsy	□ Osteoporosis	□ Osteopenia	□ Autoimmune Disease

□ Other ____

Current Medications: Please list current medications, dosages, and frequency. Include non-prescription, occasionally used medication (i.e. Tylenol, Advil, etc.), and vitamins. **If none please put N/A**.

Medication Names:	**Dosage and Frequency**:
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

Herbal Supplements:	**Dosage and Frequency:**
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

Medication Allergies: Please list any allergies to medication, latex, anesthesia, or dye and reactions you have to these medications. **If none please put N/A**.

Medication Name:	**Reaction to Medication:**
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________

Gynecologic History: **Please check one for each**

Age of First Period ___________________

How many days apart are your periods? ___________

How many days do your periods last? ___________

Are your periods regular, once a month? ◻ **Yes** ◻ **No**

Do you have excessively heavy periods? ◻ **Yes** ◻ **No**

Do you have leakage of urine? ◻ **Yes** ◻ **No**

Do you have pain with urination? ◻ **Yes** ◻ **No**

Do you have vaginal itching or burning? ◻ **Yes** ◻ **No**

Do you have hot flashes/night sweat? ◻ **Yes** ◻ **No**

Do you have breast problems? ◻ **Yes** ◻ **No**

Prior History of Abnormal Pap Smear ◻ **Yes** ◻ **No**

Prior History of Abnormal Mammogram ◻ **Yes** ◻ **No**

Have you received the Gardasil Vaccine? ◻ **Yes** ◻ **No**

Sexually Active: ◻ **Yes** ◻ **Not currently** ◻ **Never**

◻ **with Men** ◻ **with Women** ◻ **with Both**

Do you have excessive cramping with your periods? ◻ **Yes** ◻ **No**

Do you have bleeding in between your periods? ◻ **Yes** ◻ **No**

Do you have pain with intercourse: ◻ **Yes** ◻ **No**

Do you have frequency/urgency of urination? ◻ **Yes** ◻ **No**

Do you have pelvic pain? ◻ **Yes** ◻ **No**

Do you have abnormal discharge? ◻ **Yes** ◻ **No**

Do you have vaginal dryness? ◻ **Yes** ◻ **No**

Current Contraception: ◻ **None** ◻ **Condom** ◻ **Pills** ◻ **Patch** ◻ **Vaginal Ring** ◻ **IUD** ◻ **Depo-provera** ◻ **Implanon** ◻ **Diaphragm** ◻ **Tubal Ligation** ◻ **Vasectomy**

If Yes, When did you receive the vaccine? ___________

Last Period: ____/____/____ ◻ Never

Last Pap Smear: ____/____/____ ◻ Never

Last Mammogram: ____/____/____ ◻ Never

Last Colonoscopy: ____/____/____ ◻ Never

Last Bone Density: ____/____/____ ◻ Never

Obstetric **If none please put N/A**

Pregnancies ________ Abortions ________ Miscarriages ________ Ectopic ________ Living ________

Pregnancy #1 Date of Delivery________ # of Weeks ________ Sex ________ Birth Weight ________

Type of Delivery ________Place of Delivery ________Complications ________

Pregnancy #2 Date of Delivery________ # of Weeks ________ Sex ________ Birth Weight ________

Type of Delivery ________Place of Delivery ________Complications ________

Pregnancy #3 Date of Delivery________ # of Weeks ________ Sex ________ Birth Weight ________

Type of Delivery ________Place of Delivery ________Complications ________

Pregnancy #4 Date of Delivery________ # of Weeks ________ Sex ________ Birth Weight ________

Type of Delivery ________Place of Delivery ________Complications ________

Surgical/Hospitalization History: Please List any surgical procedures or hospital stays along with the month/year. **If none please put N/A**.

Month/Year	Reason/Procedure
______/______	____
______/______	____
______/______	____
______/______	____
______/______	____
______/______	____

Social History: **Please circle one for each and fill in the blank**

Smoking Current / Previous / Never Number of years ________ Packs/Day _________ Year Quit __________

Alcohol Regular / Moderate / Social / Occasional / Never Drinks/Week ______________________________

Illegal/Recreational Drugs Current / Previous / Never Specify Type of Drug ______________________________

Medications/Illicit/Recreational drugs/alcohol since last menstrual period Yes/No

If yes, Agent(s) and strength/dosage____

Exercise Regular / Occasional / None Type and Frequency ______________________________

Calcium Intake (includes drinking milk and eating yogurt) Good / Minimal / None

Diet Regular/Vegetarian/Pescatarian/Vegan/Dairy Free/Gluten Free Other: ____________________________

Caffeine Intake Yes/No If so, Type and Daily Amount (ex: Coffee, Tea, Chocolate, etc…) ________________________

Domestic Violence/Sexual Abuse____

Occupation ____

Do you always wear your seatbelt when in a motor vehicle? Yes/No

Do you live or work around cats or dogs? Yes/No

Do you:

Live with someone with TB or exposed to TB	Yes	No
Or your partner have genital herpes	Yes	No
Rash or viral illness since last menstrual period	Yes	No
History of STD, Gonorrhea, Chlamydia, HPV, Syphilis	Yes	No

Family History: Please check the follow that apply to **YOUR FAMILY** (**BLOOD RELATIVES** on both your mother and father's side) and if they are living or deceased. If they are deceased, please list the age at the time of death as well as cause of death.

	Mother	Maternal Grandmother	Maternal Grandfather	Father	Paternal Grandmother	Paternal Grandfather	Siblings	Other
Living?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	
Age								
High Blood Pressure								
Diabetes								
Heart Disease								
High Cholesterol								
Stroke								
Bleeding/Clotting Disorder								
Thyroid Disorder								
Autoimmune Disease								
Breast Cancer (please list age of diagnosis)								
BRCA Mutation Carrier								
Cervical Cancer (please list age of diagnosis)								
Ovarian Cancer (please list age of diagnosis)								
Endometrial/Uterine Cancer (please list age of diagnosis)								
Colon Cancer (please list age of diagnosis)								
Other Cancer, indicate type								
Other:								
Other:								
Other:								

Genetic History: **Please Circle one for each**

Do you or anyone in your family have a history of:

Thalassemia	Yes	No
Neural Tube Defect	Yes	No
Congenital Heart Defect	Yes	No
Down Syndrome	Yes	No
Tay-Sachs	Yes	No
Canavan Disease	Yes	No
Sickle cell disease or trait	Yes	No
Ashkenazi Jewish ancestry	Yes	No
Hemophilia or other blood disorders	Yes	No
Muscular dystrophy	Yes	No
Cystic Fibrosis	Yes	No
Mental Retardation/Autism	Yes	No
If yes, was person tested for fragile X	Yes	No
Maternal metabolic disorder	Yes	No
Patient or baby's father had a child with birth defect not listed	Yes	No
Recurrent pregnancy loss or a stillbirth	Yes	No
Other inherited genetic or chromosomal disorder	Yes	No

If yes, please list____

Blood Transfusion:

In case of a medical emergency requiring transfusion of blood or blood products, please check one of the following:

☐ I Accept ☐ I Do NOT Accept

Patient Signature ____ **Date** _____/_____/______