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Name:___________________________________
Last Name First Name
D.O.B.:___________________________________
Today's Date:______________________________
Married Single Separated Divorced Widowed
Occupation:_______________________
Height:___________________________________
Weight:___________________________________

FAMILY HISTORY
(Grandparents, Parents, Siblings, Children)
Cancer(Type):_____________________________
Heart Disease:_____________________________
High Blood Pressure:_______________________
Blood Clots/ Stroke:_______________________
High cholesterol:__________________________
Varicose Veins:____________________________
Diabetes:_________________________________
Respiratory Disease:_______________________
Asthma:__________________________________
Tuberculosis:______________________________
Kidney Disease:____________________________
Thyroid Disease:___________________________
Seizure Disorder:__________________________
Mental Illness:____________________________
Alcohol and Drug Abuse:___________________
Genetic Disorders:_________________________
Birth Defects:______________________________
Mental Retardation:________________________
Bleeding Disorders:_________________________
Other:____________________________________

YOUR MEDICAL HISTORY
Cancer (Type):_____________________________
Heart Disease:_____________________________
High Blood Pressure:_______________________
Blood Clots/ Stroke:_______________________
Rheumatic Fever:__________________________
High Cholesterol:__________________________
Liver Disease:_____________________________
Hepatitis:_________________________________
Bowel Disease:_____________________________
Varicose Veins:____________________________
Diabetes:_________________________________
Respiratory Disease:_______________________
Asthma:__________________________________
Tuberculosis:______________________________
Kidney Disease:____________________________
Thyroid Disease:___________________________
Seizure Disorder:__________________________
Migraine Headaches:________________________
Blood Transfusion:_________________________
Sickle Cell Anemia:_________________________
Mental Illness:____________________________
Depression/Lupus:__________________________
Arthritis:__________________________________
Others:____________________________________
Recent Weight Change:______________________
Change in bowel or bladder habits:_______________
Unusual Bleeding:__________________________
Unusual Bruising:__________________________
Have you ever been hospitalized? _______________
When and Why? ______________________________
Have you ever had surgery?____________________
When and Why? ______________________________
____
____

PERSONAL HISTORY
Allergies:__________________________________
Reaction:__________________________________
Current Medications/Hormones/Supplements/Herbs:__
____
____
____
Caffeine (cups per day)_______________________
Cigarettes (number per day) ___________________
Past Cigarette Use(number of years)_____________
Alcohol (number of drinks per week)______________
Exercise(type and frequency)___________________
Diet Restrictions____________________________
Do you perform breast self-exam? ______________
Is there any violence in any of your relationships?
Explain:___________________________________
____
Have you ever been sexually abused? ____________
Do you want to discuss it? _____________________

GYNECOLOGICAL HISTORY
Last menstrual period (first day)________________
Was it a normal period? _______________________
How long did your period last? __________________
How often do you have your period? _____________
Is your period regular? _________________________
# of tampons/pads used in 24 hours? _____________
Are they soaked or spotted? ____________________
Do you have cramps? __________________________
None Mild Moderate Severe
What do you take for PMS? ____________________
Other PMS symptoms? _________________________
Age period began? ____________________________
Date of last Pap Smear? _______________________
Date of last mammogram? ______________________
Do you have a history of the following (include date):
Abnormal Pap Smears:_________________________
Colposcopy/Cryo/Laser Surgery:_________________
Infertility:__________________________________
Endometriosis:_______________________________

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Alcohol and Drug Abuse:______________________
Anorexia/Bulimia:_____________________________
Chickenpox:_________________________________
Fibroids:____________________________________
Breast Lumps or Tumors:______________________
Pelvic Inflammatory Disease:___________________
Gonorrhea:__________________________________
Chlamydia:__________________________________
Herpes:_____________________________________
How frequent are your outbreaks? _______________
Syphilis:____________________________________
Genital Warts:________________________________
HPV:_______________________________________
Other Gyn problems:___________________________
____

SEXUAL HISTORY

Are you sexually active? ______________________
Sexual Preference: men/ women/ both
Are you satisfied with your sexual relations? _____
Any pain or bleeding with intercourse? __________
Age of first intercourse? _______________________
Number of partners in last 2 years? _____________

BIRTH CONTROL HISTORY

Are you using birth control now? ______________
If so, what method? _________________________
Are you satisfied with that method? ____________
What methods have you used? ________________
Any problems? _____________________________

Gardasil Vaccine_________ # of doses _________

DES Exposure:_________________________________
Ovarian Cysts:_________________________________

HORMONE HISTORY

Are you taking hormone replacement? _____________
If so, what? ___________________________________
When? ____
For how long? __________________________________
Any problems? __________________________________
Any bleeding? __________________________________
Would you like to discuss a different regimen? ______
Goals for replacement? ___________________________
____

PREGNANCY HISTORY

How many times have you been pregnant? __________
Number of children born alive? __________________
Number of Miscarriages? ________________________
Number of Abortions? ___________________________
Number of Tubal Pregnancies? ___________________
Number of children now living? __________________
Any problems with pregnancy or birth? ____________
Number of caesarean births? ______________________
Do you plan on future pregnancies? _______________

CURRENT ISSUES

Why are you here today? ________________________
____
____
____