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Name: _____ Age: _____ Date: _____

REASON FOR TODAY'S VISIT: _____

MEDICAL HISTORY: Have you or members of your immediate family ever had:

(Please indicate relationship, ie. mother, father, sibling)

	You	Family		You	Family
Unusual headaches / migraines			Stomach, gallbladder, liver problems		
Convulsions or fainting spells			Diabetes		
Eye or ear problems			Kidney or bladder disorders		
Thyroid disorder			Anemia or blood disorders		
Heart problems			Blood transfusions		
Mitral Valve Prolapse			HIV or AIDS		
High blood pressure			Blood clots in legs or lungs		
Stroke			Eating disorders		
Benign breast disease			Nervous disorders		
Breast Cancer			Birth defects or inherited disorders		
Lung problems/ asthma / TB			Other		

GYNECOLOGICAL HISTORY:

Age of first period: _____

Frequency between periods: _____

Duration of period: _____

Pain / Cramping: _____

Date of last period: _____

Last Pap: _____ Results: _____

Last Mammogram: _____ Results: _____

Last Bone Density: _____ Results: _____

Last Colonoscopy: _____ Results: _____

Have you had any history of ovarian cysts, uterine fibroids, abnormal Paps? _____

Have you had the HPV Vaccine 3/3? _____ Date: _____

Are you sexually Active? _____

Partners: Men Women Both

Type of birth control, if indicated: _____

Number of sexual partners in past year: _____

Do you have any history of any sexually transmitted infections, e.g. herpes, syphilis, gonorrhea, chlamydia, genital warts? _____

If you are postmenopausal: _____

Have you had any vaginal bleeding since menopause? _____

Have you been on hormones? _____

PAST SUGERIES:

OBSTETRICAL HISTORY:

Number of vaginal deliveries: _____

Number of Cesarean sections: _____

Complications: _____

Miscarriages: _____

Terminations: _____

Tubal pregnancies: _____

Living Children: _____

Allergies: _____

Current medications: _____

Do you smoke? Yes No
of packs per day _____

Do you drink alcohol? Yes No
of packs per day _____

Signature

Date