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Name _____ Age _____ Today's Date _____

Ethnic Background _____ Marital Status S M D W

Do you have a primary care provider? Y N Name: _____

Reason for today's appointment (Please circle the appropriate letters below)

- | | |
|--------------------------------------|--------------------------------------|
| a. Routine exam—no problems | j. Contraception |
| b. Pregnancy | k. Excess hair growth |
| c. Problems with periods (see below) | l. Premenstrual symptoms (see below) |
| d. Severe cramping | m. Vaginal infection |
| e. Unable to get pregnant | n. Bladder infection |
| f. Previous miscarriage | o. Loss of urine when unexpected |
| g. Menopause | p. Loss of stool when unexpected |
| h. Hormone therapy | |
| i. Breast problems (lump, discharge) | |

Please answer the following questions by filling in the blank or by checking the correct box.

History of your period

Age at first menstrual period _____	Heavy bleeding	Y	N
Number of days between periods _____	Irregular bleeding	Y	N
Number of days that periods last _____	Bleeding between periods	Y	N
First day of last period _____	Missed periods	Y	N
	Never had a period	Y	N
	Premenstrual symptoms:		
Have your periods completely stopped? Y N	Bloating	Y	N
When? _____	Breast soreness	Y	N
	Mood changes	Y	N

Are there any other gynecologic problems or concerns you would like to talk about?

Have you ever been a victim of physical or sexual abuse? Have you been punched, slapped, threatened or cursed at? No matter how you say it, it's all abuse. You may not be ready to talk about it today, but when you are, we are here to listen.

Name: _____

Woman's Health History

Date of last pelvic exam _____ Have you ever had an **abnormal** pap? Y N
 Date of last pap smear _____ If yes, what type of treatment did you require?
 Repeat pap smear Freezing Laser Leep/Cone
 Have you ever had a pelvic infection? Y N
 Have you ever had any of the following?
 Date of last mammogram _____ Chlamydia Y N
 Have you ever had an **abnormal** mammogram? Gonorrhea Y N
 Y N Syphilis Y N
 If yes, when? _____ Herpes Y N
 Please explain. _____ Venereal warts Y N
 Trichomoniasis Y N
 Where you treated with antibiotics? Y N

Relationship History

Are you sexually active? Y N Is intercourse painful? Y N
 Frequency of sexual intercourse per week? _____
 Do you have any questions or concerns related to sexuality that you would like to discuss? Y N
 If yes, please explain: _____

Birth Control History

Have you **ever** used a form of birth control? Y N
 What type? (see below). _____ When? _____
 Are you **now** using a form of birth control? Y N
 What type? Pills Tubal ligation Depo Provera Patch Ring
 Condom Withdraw Sponge Diaphragm IUD
 Vasectomy Other

Pregnancy History

Please complete the following information:

Pregnancies ____ Full Term ____ Premature ____ Miscarriages ____ Abortions ____ Live children ____

Year	Sex	Birth Weight	Type of Delivery	Weeks at Delivery	Complications (diabetes, hypertension, stillborn)

Surgeries and/or hospitalizations other than pregnancy

Never hospitalized

Year	Operation or Illness	Year	Operation or Illness

Name: _____

Self and Family Medical History

	<u>Yourself</u>	<u>Family (whom)</u>		<u>Yourself</u>	<u>Family (whom)</u>
Visual disturbances		_____	Ulcers or stomach problems		_____
Hearing problems		_____	Gall bladder stones		_____
Stroke		_____	Bowel problems		_____
Seizure disorders		_____	Kidney infections/stones		_____
Depression/anxiety		_____	Bladder infections		_____
Diabetes		_____	Loss of urine		_____
High blood pressure		_____	Liver problems		_____
Heart disease		_____	Bone or joint problems		_____
Heart murmur		_____	Skin problems, acne		_____
Lung disease (asthma)		_____	Easy bruising		_____
Chronic cough		_____	Anorexia, Bulimia		_____
Difficulty swallowing		_____	Breast cancer		_____
Sinus problems		_____	Uterine cancer		_____
High cholesterol		_____	Ovarian cancer		_____
Thyroid disease		_____	Cervical cancer		_____
Hepatitis or jaundice		_____	Colon cancer		_____

Recent medical tests

Have you had any lab tests, x-rays or ultrasounds done recently? Y N

Please list: _____

Have you ever had a colonoscopy? Y N When: _____

Please list the names and doses of any medicine and/or vitamins you take:

Social history

Have you had previous marriages? Y N

Do you exercise? Y N Number of times each week? _____

Do you smoke cigarettes? Y N Have you **ever** smoked? Y N

How many years have you smoked? _____ Number of packs per week? _____

Have you ever tried to quit? Y N

Do you drink alcohol? Y N If yes, how many glasses per week? _____

Do you or have you used recreational drugs? Y N

Have you ever lived or traveled outside of the U.S.? Y N

Where? _____

Have you ever worked with chemicals, heavy metals or radiation? Y N

Do you have any allergies? Y N What are you allergic to? _____