Name: _____ DOB: _____/_____/_____ PCP: _____ DATE: _____/_____/_____

PERSONAL/MEDICAL HISTORY

Anxiety/Depression ☐ Yes ☐ No

Anemia ☐ Yes ☐ No

Asthma/Lung condition ☐ Yes ☐ No

Arthritis ☐ Yes ☐ No

Bleeding disorder ☐ Yes ☐ No

Bowel problems ☐ Yes ☐ No

Cancer: _____

Diabetes ☐ Yes ☐ No

Elevated cholesterol ☐ Yes ☐ No

Endometriosis/PCOS ☐ Yes ☐ No

Heart disease ☐ Yes ☐ No

High blood pressure ☐ Yes ☐ No

Headaches ☐ Yes ☐ No

Kidney disease/stones ☐ Yes ☐ No

Liver disease/Hepatitis ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Thyroid disorder ☐ Yes ☐ No

Other: _____

SOCIAL HISTORY

Married/Single/Divorced/Widowed/Separated

Smoke: ☐ Yes ☐ No Packs per day: _____

Alcohol: ☐ Yes ☐ No How much? _____

Street drugs: _____

Marijuana: ☐ Medical ☐ Recreational

Sexual preference: _____

ALLERGIES – INCLUDE MEDICATION REACTION

_____

_____

GYNECOLOGIC HISTORY

Last pap smear: _____ ☐ Normal ☐ Abnormal

Last mammo: _____ ☐ Normal ☐ Abnormal

Last colonoscopy: _____ ☐ Normal ☐ Abnormal

Last DEXA (bone) scan: _____ ☐ Normal ☐ Abnormal

Previous treatment for abnormal pap smears?

☐ Colpo ☐ Cryo ☐ LEEP ☐ Conization ☐ N/A

Last menstrual period: _____

Age of first period: _____

Periods occur every _____ days and last _____ days

☐ Heavy ☐ Clots ☐ Pain ☐ Cramping ☐ Irregular bleeding

Average # of pads/tampons used per day: _____

Menopausal: ☐ Yes ☐ No Age began: _____

Hysterectomy: ☐ Yes ☐ No When? _____

Complaints of: ☐ Breast pain ☐ Infertility ☐ Fibroids ☐ Ovarian cysts

☐ Pain w/ intercourse ☐ Vaginal infections ☐ Leaking of urine

Have you ever been diagnosed with any of the following:

Gonorrhea ☐ Yes ☐ No

Chlamydia ☐ Yes ☐ No

Herpes (Genital) ☐ Yes ☐ No

HPV/Genital warts ☐ Yes ☐ No

Hepatitis B or C ☐ Yes ☐ No

HIV ☐ Yes ☐ No

Syphilis ☐ Yes ☐ No

Number of sexual partners (in lifetime): _____

Current birth control method: _____

Previous birth control method(s): _____

_____

_____

PREGNANCY HISTORY

Number of Miscarriages: _____ Abortions: _____ Ectopic: _____ Live Births: _____

Date	Gestational Age	Birth Weight	Gender	C-section or Vaginal	Early Labor	Complications

SURGICAL HISTORY

Ablation Date: _____ Laparoscopy Date: _____

Breast surgery Date: _____ Ovaries removed Date: _____

D&C Date: _____ Tubal ligation Date: _____

Hysterectomy Date: _____

☐ Appendectomy ☐ Back surgery ☐ Bowel ☐ Fibroid removal ☐ Gallbladder ☐ Tonsillectomy

Other: _____

FAMILY HISTORY

Breast Cancer ☐ Yes ☐ No Family Member: _____

Ovarian Cancer ☐ Yes ☐ No Family Member: _____

Colon Cancer ☐ Yes ☐ No Family Member: _____

Other: _____

_____

CURRENT MEDICATIONS

List all medications taken daily

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____