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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