

PLEASE COMPLETE FRONT AND BACK

NAME _____ DATE OF BIRTH _____

REASON FOR VISIT _____

Have you ever had a pap smear? _____ When? _____ Were your results normal? _____
Have you ever had a colonoscopy? _____ When? _____ Were your results normal? _____
Have you ever had a mammogram? _____ When? _____
Do you perform self-breast exams? _____ How often? _____

Medical History- Have you ever had any of the following?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Hepatitis: Type _____ | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Herpes: Type _____ | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia or Blood Disorder | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Kidney/Bladder Problems | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Stomach, Bowel or Gallbladder Problems | <input type="checkbox"/> Breast Problems | <input type="checkbox"/> Female or Sexual Problems | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Birth Defects or Inherited Diseases | <input type="checkbox"/> Domestic Violence | | |
| <input type="checkbox"/> Cancer: Type _____ | <input type="checkbox"/> Other Medical Problems: _____ | | |

Family Medical History- Has a member of you family had any of the following?

- | Relationship | Age at Onset | Relationship | Age at Onset |
|---|--------------|---|--------------|
| <input type="checkbox"/> High Cholesterol _____ | _____ | <input type="checkbox"/> Hepatitis _____ | _____ |
| <input type="checkbox"/> Heart Disease _____ | _____ | <input type="checkbox"/> Cancer _____ | _____ |
| <input type="checkbox"/> High Blood Pressure _____ | _____ | Type: _____ | _____ |
| <input type="checkbox"/> Diabetes _____ | _____ | <input type="checkbox"/> HIV/Aids _____ | _____ |
| <input type="checkbox"/> Thyroid Problems _____ | _____ | <input type="checkbox"/> Breast Problems _____ | _____ |
| <input type="checkbox"/> Anemia or Blood Disorder _____ | _____ | <input type="checkbox"/> Birth Defect or Inherited Diseases _____ | _____ |
| <input type="checkbox"/> Other Medical Problems: _____ | | | |

Surgical History- Please list all surgeries with the month and year they occurred

Surgery	Month/Year
_____	_____
_____	_____
_____	_____
_____	_____

Allergies- Please list all known allergies (drug, food, environmental) No Known

Medications please list ALL medications you are currently taking. Including Over-the-counter medications, vitamins and herbal substance No current medications

Medication	Dosage/Instructions

Menstrual History

Age of 1st period _____ # of days between period _____ Date of last period _____ Length of period _____
 Flow (circle one) Light Medium Heavy Method of Birth Control: _____
 Do you ever experience pain/cramping during your cycle? _____ Clotting _____
 Do you have breakthrough bleeding between cycles? _____
 Are you post menopause? _____ Age at Menopause _____
 Are you on Hormone Replacement Therapy? _____

Pregnancy History

Please list the total number of each: Number of pregnancies _____
 How many were Full Term Births _____ Premature Births _____ # of Living Children _____
 Pregnancies resulting in the birth of multiple children: _____
 Number of Terminated Pregnancies _____ Miscarriages _____ Ectopic Pregnancies _____

# of weeks at Delivery	Birth Date	Birth Weight	Sex	Type of Delivery	Anesthesia Type	Complications? Yes or No	Location

Social History

Tobacco Use (circle one) Never Current Former Type: _____ Amount per day _____
 Age started _____ Age stopped _____
 Alcohol Use Yes or No Current or Former _____ Type: _____ Amount per week _____
 Street Drug Use _____ Current or Former _____ Type _____ Amount per day _____
 Do you exercise on a regular basis? _____ What type _____ # of hours per week _____
 Education Level _____ Relationship status (circle one) Married Single
 Are you sexually active? _____ Do you have more than one partner? _____ Sexual preference? _____