Name___________________________ Age_______ Doctor_____________________ Last period_________

Please list any problems or concerns you are currently having: ___________________________________

____

CURRENT MEDICATIONS	STRENGTH	FREQUENCY TAKEN	DATE STARTED

MEDICATION ALLERGIES:____

Have you had a Hysterectomy? If so, what kind?____

List any other surgeries you have had:

____ Date______________________

____ Date______________________

____ Date______________________

____ Date______________________

Diagnosed medical conditions (Including Mental Health):

____

____

GYN/OB HISTORY:

Total # of pregnancies ____ Live births ____ Miscarriage ____ Abortion ____ Ectopic ____

Date of Delivery	Vaginal/C-Section	M / F	Weight	Complications	Breast Fed
					Yes No
					Yes No
					Yes No
					Yes No

Last Pap Smear _________ Normal? Yes/No Last Bone Density _________ Normal? Yes/No

Last Pelvic Exam _________ Normal? Yes/No Last Colonoscopy _________ Normal? Yes/No

Last Mammogram_________ Normal? Yes/No

CHECK ANY THAT APPLY TO YOU:

- ☐ Painful periods
- ☐ Abnormal pap
- ☐ Bladder leakage
- ☐ Abnormal bleeding
- ☐ Colposcopy
- ☐ Frequent urination
- ☐ Painful Intercourse
- ☐ LEEP
- ☐ Trouble empting bladder

MENSTRUAL INFORMATION:

Age of 1st Period_______ Are your periods Regular / Irregular

Average days of flow ______ # of days between periods_______

SEXUAL HISTORY: Are you sexually active? Yes No Have you ever been active? Yes No

# of partners the last 6 months______ last year______ last 2 yrs_____ since being active______

Is your partner Male or Female? Are you currently using a birth control method Yes No

Your birth control method_______________________ Partner's method_____________________

SOCIAL HISTORY: Check any that apply

Cigarette smoker	☐	Cigarettes smoked per day _______: # of years smoked _______
Previous Smoker	☐	Date quit _________
Consume Caffeine	☐	Number of Drinks per day _________
Consume Alcohol	☐	Number of Drinks per day _________
Use recreational drugs	☐	What type ______________________
Excersise	☐	Number of days per week _________
Experienced Abuse	☐	What type of abuse ______________________________________
Interested in pregnancy	☐	Now Future
Do self Breast exams	☐	Daily Weekly Monthly

FAMILY HISTORY: Check any that apply

Breast Cancer	☐	List relative:____
Cervical Cancer	☐	List relative:____
Uterine Cancer	☐	List relative:____
Ovarian Cancer	☐	List relative:____
Colon Cancer	☐	List relative:____
Prostate Cancer	☐	List relative:____
Melanoma	☐	List relative:____
Other Cancer	☐	List relative:____
Diabetes	☐	List relative:____
Stroke	☐	List relative:____
Heart Attack	☐	List relative:____
Osteoporosis	☐	List relative:____
Thyroid Disorder	☐	List relative:____
Bleeding Disorder	☐	List relative:____
Mental Illness	☐	List relative:____

Patient Signature____ Date______________