Name **Date of Birth** **Date of Visit**

Reason for today's visit

GYNECOLOGICAL HISTORY

Contraception Method	Last Period
Last Mammogram	Last Pap Smear
Age at onset of period	Age at Menopause
Have you had a Hysterectomy? No Yes When?	
Do you have a period each month? No Yes	Duration
Painful Periods: No Yes Mild Moderate Severe	
Do you bleed between periods? No Yes	
Do you have pain or bleeding with Intercourse? No Yes	
Do you have unusual vaginal discharge/itching? No Yes	
Abnormal Pap Smears? No Yes When?	
Treatment? STD's?	
Do you do regular self breast exams? No Yes	
Age first Intercourse: # of sexual partners >5 or <5	
Do you lose urine with cough or sneeze? No Yes	

REVIEW OF SYSTEMS (circle if symptomatic)

Constitutional: Weight change, Fever, Illness

HEENT: Eyes, Ears, Throat or Nose problems

Cardiovascular: Irregular Heart Rate, Chest Pain

Breasts: Discharge, Pain, Lumps

Respiratory: Short of Breath, Cough, Wheezing

Gastrointestinal: Diarrhea,Constipation,Pain,Blood in Stool

Musculoskeletal: Joint Pain/Swelling,Injury,Varicose Veins

Muscle Pain

Skin: Moles, Acne, Problems

Psychiatric: Depression,Counseling, Thoughts of suicide,

Relationship problems

Neurological: Headaches, Weakness, Fainting, Seizures

Other

OBSTETRICAL HISTORY

#of Pregnancies___#of Vaginal Deliveries___ #of C-Sections___#of Miscarriages___#of Abortions___ #of Living Children____

SURGERIES

HOSPITALIZATIONS

DRUG ALLERGIES

CURRENT MEDICATIONS

MEDICAL HISTORY (Check if you have)

1. Anemia___
2. Arthritis___
3. Asthma___
4. Blood Transfusion___
5. Breast Cancer____
6. Other Cancer_____
7. DES Exposure___
8. Diabetes___
9. DVT's___
10. Gallbladder Disease___
11. Headaches/Migraines___
12. Heart Disease(MVP-RHD)___
13. High Blood Pressure___
14. High Cholesterol___
15. Jaundice/Hepatitis___
16. Kidney/Bladder problems___
17. Osteoporosis___
18. STD: HIV___
    Chlamydia___ Gonorrhea___
    Herpes___ Genital Warts___
19. Thyroid Disease
20. Other?_____

HABITS

1. Marital Status: S M D Sep Partner
2. Employed? Full Time Part-Time
   Type of Work?_____
3. Alcohol Use? YES NO
   Daily Weekly Social
4. Smoke? YES NO
   How Much?_____
5. Recreational Drug Use? YES NO
6. Caffeine? Yes NO
   How Much?_____
7. Calcium Supplement? YES NO
8. Exercise? YES NO
   What Kind?_____
9. Any Safety concerns YES NO
10. Do you feel safe at home?
    YES NO
    Explain:_____
    _____

FAMILY HISTORY (indicate family member)

1. Arthritis___
2. Breast Cancer___
3. Colon Cancer___
4. Other Cancer___
5. Diabetes___
6. Genetic Disorder___
8. Heart Disease___
9. High Blood Pressure___
10. Osteoporosis___
11. Renal Disease___
12. Stroke___
13. Thyroid Disease___

Patient Signature **Physician Signature**