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

Reason for today's visit

GYNECOLOGICAL HISTORY	REVIEW OF SYSTEMS (Circle Yes or No and symptom)
Contraception Method Last Period	YES / NO = Constitutional: Weight change, Fever, Illness
Last Mammogram Last Pap Smear	YES / NO = HEENT: Eyes, Ears, Throat or Nose problems
Age at onset of period Age at Menopause	YES / NO = Cardiovascular: Irregular Heart Rate, Chest Pain
Have you had a Hysterectomy? No Yes When?	YES / NO = Breasts: Discharge, Pain, Lumps
Do you have a period each month? No Yes Duration	YES / NO = Respiratory: Short of Breath, Cough, Wheezing
Painful Periods: No Yes Mild Moderate Severe	YES / NO = Gastrointestinal: Diarrhea,Constipation,Pain,
Do you bleed between periods? No Yes	Blood in stool
Do you have pain or bleeding with Intercourse? No Yes	YES / NO = Musculoskeletal: Joint Pain/Swelling,Injury,
Do you have unusual vaginal discharge/itching? No Yes	Varicose veins, Muscle Pain
Abnormal Pap Smears? No Yes When?	YES / NO = Skin: Moles, Acne, Problems
Treatment? STD's?	YES / NO = Psychiatric: Depression,Counseling, Thoughts
Do you do regular self breast exams? No Yes	of suicide, Relationship problems
Age first Intercourse: # of sexual partners >5 or <5	YES / NO = Neurological: Headaches, Weakness, Fainting,
Do you lose urine with cough or sneeze? No Yes	Seizures
Do you have blood in your urine, frequent urination,	Other
pain with urination? No Yes	

OBSTETRICAL HISTORY

#of Pregnancies____#of Vaginal Deliveries____ #of C-Sections____#of Miscarriages____#of Abortions____ #of Living Children____

SURGERIES	HOSPITALIZATIONS

DRUG ALLERGIES	CURRENT MEDICATIONS

PERSONAL MEDICAL HISTORY (Check if you have)

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

FAMILY HISTORY (indicate family member)

1. Arthritis________________
2. Cancer - Breast________________
3. Cancer - Colon________________
4. Cancer - Ovarian________________
5. Cancer - Uterine________________
6. Cancer - Other________________
7. Diabetes________________
8. Genetic Disorder________________
9. Heart Disease________________
10. High Blood Pressure________________
11. Osteoporosis________________
12. Renal Disease________________
13. Stroke________________
14. Thyroid Disease________________

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:______________________
    ____

Do you have an Ashkenazi Jewish background? Yes No

Patient Signature **Physician Signature**