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

**Gender Identity:** **Sex at Birth:** **Pronouns:** Have you received the

Reason for Todays Visit: **COVID 19** Vaccination?____

## 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 | |
| Any new sexual partners since last STI screening? No Yes | |
| Do you have unusual vaginal discharge/itching? No Yes | |
| Abnormal Pap Smears? No Yes When? | |
| Do you do regular self breast exams? No Yes | |
| 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

## 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. Migraines?_____
12. Heart Disease(MVP-RHD)___
13. High Blood Pressure___
14. High Cholesterol___
15. Jaundice/Hepatitis___
16. Kidney/Bladder problems___
17. Osteoporosis___
18. Current STI?___
19: Mental Health Disorder_____
- Anxiety__ -Depression__ -Other?___
20. Thyroid Disease
21. Other?_____

## 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___

## HABITS

1. Relationship Status: S M D 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

Do you have an Ashkenazi Jewish background? __

**Patient Signature** **Physician Signature**

Update Date_____

Patient Signature_____ Physician Signature_____