NAME:_____DOB_____ DATE OF LAST PERIOD_____

MARITAL STATUS: MARRIED____SINGLE_____DIVORCED_____SEPARATED_____
GYNECOLOGIC HISTORY: Menstrual history: Age started_____# day between_____
days flow_____pads per day_____ SYMPTOMS: Cramps_____nausea/vomiting_____
Age of menopause _____other_____
Have you had: Vaginal infection (s)_____What types_____ _
Herpes_____ Tubal Infection_____Urinary Infection_____Warts_____
Bleeding after intercourse_____Bleeding between periods_____Pain with intercourse_____
Abnormal Paps_____Bleeding after menopause_____Other_____
CONTRACEPTIVE HISTORY: Present method_____How long?_____
Methods used in past, associated problems & reasons for discontinuing, list from earliest age,
Include pills, IUD, diaphragm, condoms, etc. 1._____2._____
Tubal Ligation Date: _____
PREGNANCY HISTORY: Total number:____ Full Term_____Cesarean Section_____
Miscarriages or Abortions_____Ectopic_____Premature_____
Pregnancy Problems: Infection_____Bleeding_____High Blood Pressure_____
PAST MEDICAL HISTORY: How is your general health_____
Serious illnesses and dates_____
Hospitalization/Operations date & reasons_____

Medications:_____Allergies_____
Chronic diseases: Thyroid disease_____Heart disease_____High blood pressure_____Stroke_____
Breast disease/biopsy_____Lung disease/asthma____Kidney/Liver _____ anemia /blood prob_____
Bowel/stomach problems____Cancer or tumor_____ Diabetes____Osteoporosis_____Other_____
FAMILY HISTORY: Any history of the following in your family?
Cancer____Diabetes_____Heart attack under age 50_____Stroke_____High Blood Pressure_____
Birth defects__Breast or ovarian cancer___Osteoporosis/loss of height___Bowel/stomach disease____
Kidney/liver disease_____Thyroid disease_____Other_____
FATHER: Living:_____age_____Age of death_____Illness/cause of death_____
MOTHER: Living:_____age_____ Age of death_____Illness/cause of death_____
SOCIAL HISTORY: Occupation: _____
Do you: Smoke_____how much per day_____packs; how long?_____
Drink alcohol_____how much per week_____servings_____
Do self breast examination_____Do you want information_____
REVIEW OF SYSTEMS: Weight: Stable_____Loss____Gain____How much: _____pounds
Vision changes_____Trouble swallowing_____Lumps in neck_____Breast lumps____skin lesions_____
Skin changes____Chest pain_____ Shortness of breath_____Asthma or breathing difficulties_____
Muscular weakness_____Joint pains_____Headaches_____Dizziness_____
Bowels: regular____constipated____loose_____use laxatives_____bloody___ recent change_____
Urination: normal_____frequent_____retention_____burning_____blood____leakage_____
Unusual vaginal discharge: _____color_____itch_____odor_____
Other issues you wish to discuss with your Health care provider_____

I have filled out this form to the best of my abilities: Date:_____
SIGNATURE:_____