PLEASE COMPLETE FRONT AND BACK

NAME________________________________ DATE OF BIRTH__________________
REASON FOR VISIT____

Have you ever had a pap smear? _______ When? ______________ Were your results normal? _______
Have you ever had a colonoscopy? ______ When? ______________ Were your results normal? _______
Have you ever had a mammogram? ______ When? ______________
Do you perform self-breast exams? ______ How often? ____________

Medical History- Have you ever had any of the following?

☐ High Cholesterol	☐ Heart Disease	☐ Rheumatic Fever	☐ Infertility
☐ High Blood Pressure	☐ Asthma	☐ Tuberculosis	☐ Diabetes
☐ Thyroid Problems	☐ HIV/Aids	☐ Chlamydia	☐ Gonorrhea
☐ Hepatitis: Type_________	☐ Syphilis	☐ Herpes: Type__________	☐ Liver Disease
☐ Anemia or Blood Disorder	☐ Blood Transfusion	☐ Kidney/Bladder Problems	☐ Infertility
☐ Stomach, Bowel or Gallbladder Problems	☐ Breast Problems	☐ Female or Sexual Problems	☐ Sexual Abuse or
	☐ Birth Defects or Inherited Diseases		☐ Domestic Violence
☐ Cancer: Type _________	☐ Other Medical Problems: ______________________		

____
____

Family Medical History- Has a member of you family had any of the following?

	Relationship	Age at Onset		Relationship	Age at Onset
☐ High Cholesterol	__________	______	☐ Hepatitis	__________	______
☐ Heart Disease	__________	______	☐ Cancer	__________	______
☐ High Blood Pressure	__________	______	Type:	__________	______
☐ Diabetes	__________	______	☐ HIV/Aids	__________	______
☐ Thyroid Problems	__________	______	☐ Breast Problems	__________	______
☐ Anemia or Blood Disorder	__________	______	☐ Birth Defect or Inherited Diseases	__________	______

☐ Other Medical Problems: ____

Surgical History- Please list all surgeries with the month and year they occurred

Surgery	Month/Year
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________

Allergies- Please list all known allergies (drug, food, environmental) ☐ No Known Allergies

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Medications please list ALL medications you are currently taking. Including Over-the-counter medications, vitamins and herbal substance ☐ No current medications

Medication	Dosage/Instructions
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Menstrual History

Age of 1st period ______ # of days between period ______ Date of last period ______ Length of period _______
Flow (circle one) Light Medium Heavy Method of Birth Control: ______________________________
Do you ever experience pain/cramping during your cycle? ________________ Clotting ______________________
Do you have breakthrough bleeding between cycles? ____________________
Are you post menopause? ______ Age at Menopause ______ Are you on Hormone Replacement Therapy? _______

Pregnancy History

Please list the total number of each: Number of pregnancies ________
How many were Full Term Births _______ Premature Births ________ # of Living Children_________
Pregnancies resulting in the birth of multiple children: ________
Number of Terminated Pregnancies ______ Miscarriages _________ Ectopic Pregnancies __________

# of weeks at Delivery	Birth Date	Birth Weight	Sex	Type of Delivery	Anesthesia Type	Complications? Yes or No	Location

Social History

Tobacco Use (circle one) Never Current Former Type: __________________ Amount per day ___________
Age started ____________ Age stopped ______________
Alcohol Use Yes or No Current or Former _____________Type: _______________ Amount per week __________
Street Drug Use _________ Current or Former____________ Type________________ Amount per day ___________
Do you exercise on a regular basis? ________ What type _____________________ # of hours per week __________
Education Level _______________________ Relationship status (circle one) Married Single
Are you sexually active? ________ Do you have more than one partner? _________ Sexual preference? ____________