TODAY'S DATE: _____

IF YOU FEEL UNCOMFORTABLE ANSWERING ANY OF THE FOLLOWING QUESTIONS YOU MAY LEAVE THEM BLANK AND DISCUSS THE ISSUES WITH YOUR DOCTOR – ALL INFORMATION IS CONFIDENTIAL			
YOUR NAME:	DATE OF BIRTH:	AGE NOW:	
ADDRESS:	CITY:	STATE:	ZIP:
DAYTIME PHONE:	EVENING PHONE:		
PARTNER'S NAME:	PARTNER'S AGE:	S☐ M☐ D☐ W☐ S☐	HOW LONG TOGETHER?
YOUR OCCUPATION AND EMPLOYER:		REFERRING DOCTOR:	
REASON FOR TODAY'S VISIT:			

PERSONAL AND FAMILY MEDICAL HISTORY

FATHER	STILL LIVING?	AGE NOW OR AGE AT DEATH:	MEDICAL PROBLEMS:
MOTHER	STILL LIVING?	AGE NOW OR AGE AT DEATH:	MEDICAL PROBLEMS:
BROTHER/SISTER	HOW MANY? MALE:	FEMALE:	MEDICAL PROBLEMS:
CHILDREN	HOW MANY? MALE:	FEMALE:	MEDICAL PROBLEMS:

U CHECK ALL THAT APPLY	U SELF	U FAMILY	COMMENTS
Headache/Visual Disturbances			
Heart Disease			
High Blood Pressure			
Lung Disease			
Breast Problems			
Gall Bladder/Liver Disease			
Stomach Disease/Ulcers			
Bowel(Intestinal) Disorders			
Kidney Disease			
Bladder Disease/Urine Leak			
Anemia/Blood Disease			
Varicose Veins/Blood Clots			
Thyroid Disease			
Diabetes			
Cancer (ANY Type)			
Seizures/Neurologic Disease			
Depression/Psychiatric Disorders			
Arthritis			
Skin Disease			
Stroke			
High Cholesterol/Triglycerides			
Sexually Transmitted Diseases			
Infertility			
Endometriosis			
DES Exposure			
Other			

SURGICAL HISTORY

DATE	SURGERY	SURGEON		DATE	SURGERY	SURGEON

HEIGHT: ft. in. USUAL WEIGHT: AMOUNT OF WEIGHT CHANGE OVER THE PAST YEAR:

DESCRIBE YOUR DIET: TYPE OF EXERCISE: HOURS/WEEK:

SMOKING AMOUNT: ALCOHOL INTAKE: CAFFEINE INTAKE: DRUG HISTORY:

DRUG OR FOOD ALLERGIES:

BLOOD TYPE: BLOOD TRANSFUSION HISTORY:

CURRENT MEDICATION	DOSE		CURRENT MEDICATION	DOSE

GYNECOLOGIC HISTORY

AGE AT FIRST PERIOD: FIRST DAY OF YOUR LAST PERIOD: WAS IT NORMAL? IF MENOPAUSAL, AT WHAT AGE?

HOW OFTEN ARE YOUR PERIODS? HOW MANY DAYS OF FLOW? HOW HEAVY? PADS? TAMPONS?

HOW BAD ARE YOUR CRAMPS? ☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE LIST MEDICATIONS NEEDED FOR CRAMPS:

LAST PAP SMEAR DATE & RESULTS: PREVIOUS ABNORMAL PAPS?

LAST MAMMOGRAM DATE & RESULTS: PREVIOUS ABNORMAL MAMMOGRAMS?

PREVIOUS VAGINITIS? (YEAST/TRICHOMONAS/OTHER) HAVE YOU HAD TUBES TIED?

CONTRACEPTIVE HISTORY

DATE	METHOD	REASON STOPPED		DATE	METHOD	REASON STOPPED

PREGNANCY HISTORY

TOTAL NUMBER OF PREGNANCIES: # OF DELIVERIES: # OF MISCARRIAGES: # OF ABORTIONS: # OF LIVE BIRTHS:

DELIVERY DATE	NUMBER OF WEEKS PREGNANT	TYPE OF DELIVERY OR PREGNANCY LOSS	LENGTH OF LABOR	BABY'S BIRTH WEIGHT	SEX	TYPE OF ANESTHESIA IF USED	OTHER INFORMATION