NAME ________________________________ AGE ______________________Date of Birth ________________________

Explain the reason you are seeing the doctor today ____

____

Primary Care Physician ____________________________________

If you are a new patient – how did you hear of our practice? Friend/Relative, TV Phonebook, Newspaper, Referral, Other ________________________

GYN HISTORY

1. Have you ever been pregnant? Yes or No
   If yes, how many times? ________
   How many vaginal deliveries? ________ C-Sections ______ Miscarriages ________ Terminations __________
   Tubal/Ectopic ____________
2. Have you ever had an abnormal pap? Yes or No
   If yes, how was it treated? ____
3. Have you ever had a pelvic infection (PID)? Yes or No
4. Do you ever have any leaking of urine? Yes or No
5. Do you have pain with intercourse? Yes or No
6. Do you have any abnormal vaginal discharge? Yes or No
7. How often so you so self-breast exams? ____
8. **Date of last mammogram** ______________________ **Date of last pap** ___________________________________
9. Do you know if you are immune to rubella (German Measles)? ____
10. What type of birth control do you use? ____
    -Optional- Please list sexual orientation ____
11. Are you or have you ever been physically, emotionally, or sexually abused? ________________________________

MENSTRUAL HISTORY

1. Age of first period ________________________
   a. **First day of last period** ___________ **Update** _____________ **Update** ________
   b. How often does period come ______________________ How long does it last ________________________
   c. Do you have pain with your period? ____
2. Age at menopause ____ (If you are not menopausal, skip down to surgical history)
   a. Do you have any postmenopausal symptoms? ____
   b. Any bleeding? ____

PATIENT SURGICAL HISTORY

Please list any surgeries you have had:

____
____
____

MEDICATIONS

Please list any medications you are currently taking (including birth control/vasectomy/tubal): (and dose if known)

____
____

ALLERGIES

Please list any allergies or reactions that you have (**especially latex or silicone**):

____
____

UPDATE____

PAST MEDICAL HISTORY

Do you currently have or have you ever had: (circle yes or no)

High Blood Pressure	Yes	No	If yes, please explain ___________________
Heart Disease	Yes	No	If yes, please explain ___________________
Heart Murmur	Yes	No	If yes, please explain ___________________
Rheumatic Fever	Yes	No	If yes, please explain ___________________
Diabetes	Yes	No	If yes, please explain ___________________
Lung Disease	Yes	No	If yes, please explain ___________________
COPD (Lung Disease)	Yes	No	If yes, please explain ___________________
Emphysema	Yes	No	If yes, please explain ___________________
Asthma	Yes	No	If yes, please explain ___________________
Kidney Disease	Yes	No	If yes, please explain ___________________
Urinary Tract Problem	Yes	No	If yes, please explain ___________________
Seizures	Yes	No	If yes, please explain ___________________
Neurologic Disease example: Multiple Sclerosis	Yes	No	If yes, please explain ___________________
Psychiatric Illness	Yes	No	If yes, please explain __________________
Cancer	Yes	No	If yes, please explain ___________________
Thrombosis/Embolism (Blood Clots)	Yes	No	If yes, please explain ___________________
Hepatitis	Yes	No	If yes, please explain ___________________
Liver Disease	Yes	No	If yes, please explain ___________________
Anemia	Yes	No	If yes, please explain ___________________
Blood Disorders	Yes	No	If yes, please explain ___________________
Osteoporosis	Yes	No	If yes, please explain ___________________
Stroke	Yes	No	If yes, please explain ___________________
Thyroid Disorder	Yes	No	If yes, please explain ___________________
Breast lump/problem	Yes	No	If yes, please explain ___________________
Other (please list)	Yes	No	If yes, please explain ___________________

Have you ever been told you have or have had MRSA (methicillin resistant infection)? Yes No

FAMILY HISTORY

Has anyone in your family ever been diagnosed with: (circle yes or no)

Heart Disease	Yes	No	If yes, please explain ___________________
Diabetes	Yes	No	If yes, please explain ___________________
Osteoporosis	Yes	No	If yes, please explain ___________________
Thrombosis (Clotting Disorder)	Yes	No	If yes, please explain ___________________
Breast Cancer	Yes	No	If yes, please explain ___________________
Colon Cancer	Yes	No	If yes, please explain ___________________
Ovarian Cancer	Yes	No	If yes, please explain ___________________
Uterine Cancer	Yes	No	If yes, please explain ___________________
Cervical Cancer	Yes	No	If yes, please explain ___________________
Other Cancer	Yes	No	If yes, please explain ___________________
Birth Defects	Yes	No	If yes, please explain ___________________
Cystic Fibrosis (Lung Disease)	Yes	No	If yes, please explain ___________________
Muscular Dystrophy	Yes	No	If yes, please explain ___________________
Tay Sachs Disease	Yes	No	If yes, please explain ___________________

SOCIAL HISTORY

Are You: Married Single Divorced Widowed Separated

Occupation: ____ Full-time Part-time Retired

Do you smoke? Yes or No

Have you tried to stop? Yes or No

Do you drink alcoholic beverages? Yes or No

Do you use recreational drugs? Yes or No

(marijuana, cocaine, other)

DIET/EXERCISE

Any diet restrictions? Yes or No If yes, what type ___________________________________

What type of exercise do you do and how often? ____

____

____

Have you ever had your cholesterol tested? ________________________________ Date done ___________________________

REVIEW OF SYMPTOMS

Have you experienced any of the following symptoms within the past year? (Check all that apply)

		UPDATE
____	Unexplained fever, weight loss, weight gain	_______
____	Loss of vision, other visual disturbance	_______
____	Ringing in ears, nose bleeds, difficulty swallowing	_______
____	Chest pain, shortness of breath, palpitations	_______
____	Wheezing, difficulty breathing, chronic cough	_______
____	Change in bowel habits, blood in stools,chronic diarrhea	_______
____	Muscle weakness, joint pain	_______
____	Skin rashes, breast lumps, breast discharge	_______
____	Headaches, numbness	_______
____	Depression, sleeping difficulties	_______
____	Blood in urine or pain with urination	_______

If we need to contact you where do you prefer we call? Please fill in all that apply:

Home # ______________________________ Work # ___________________________

Other (cell phone, message phone, etc. – please explain) ____________________________________

____ ______________________________

Signature Date

- **UPDATED (SIGN AND DATE)** ____
- **UPDATED (SIGN AND DATE)** ____
- **UPDATED (SIGN AND DATE)** ____