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Patient's Name_____ **DOB:** ____/____/_____ **Date:** _____
Age:_____ **Race** _____ **Referred by:** _____
Reason for this Appt_____

Menstrual History

Last Period _____ **Age at onset** _____ **Regular** Yes No **Flow** Light Mod Heavy
Cycle Length _____ days (from start to start) Duration: _____ days **Postmenopausal** Yes No
Date of last Pap smear: _____ **Current Birth Control Method** _____

Bleeding between menses Vaginal discharge PMS
Bleeding after intercourse Vaginal irritation Large Clots
Night Sweats / Hot Flashes Irregular Bleeding Pains / Cramps
Other: _____

Family History: Please √ if any of these have been found in any of your close relatives (parents, grandparents, brother, sister or children)

	Whom?		Whom?		Whom?
High Blood Pressure		Tuberculosis		**Cancer**	
Kidney Problems		Alzheimer's / Dementia		Breast/Age	
High Cholesterol		Depression		Melanoma	
		Suicide			
Diabetes		Blood Clots		Ovarian	
Heart Disease		Osteoporosis		Colon	
Stroke		Birth Defect		Other	

Medication Allergies

Drug	Reaction

List ALL Medication(s) you are currently taking

Drug	Dose	How Often

Drug	Dose	How Often

Past Medical History:

Have you ever had a blood transfusion? Yes No
Would you have a blood transfusion to save your life? Yes No
Have you ever had any of the following illnesses? Circle all that apply

Heart Trouble Osteoporosis Chronic Fatigue Breast Problems / Nipple Discharge
Kidney / Bladder Problems DES exposure Anemia Hemorrhoids
High Blood Pressure Dysplasia / HPV Cholesterol Anesthesia Problems
Low Blood Pressure Fibroids Hepatitis Heart Murmur / MVP
Thyroid Problems Pelvic Prolapse Anxiety Prophylactic antibiotics before procedures
Migraine Headaches Depression Varicose Veins Polycystic ovarian syndrome
Rectal Bleeding Endometriosis Diabetes Genital Herpes Genital Warts
Stomach Trouble /Ulcer/ IBS Seizures Blood Disorders Abnormal pap smear

STD type_____Cancer (type) _____ Are you HIV positive?_____

Surgical History: (Including Hospitalizations)

Date	Procedure

Pregnancies _____ **Miscarriages** _____ **Abortions**____

Date	Delivery Type	Sex	Lbs/Oz	Complications

Smoker? **No** **Former Smoker** **Current Smoker (packs per day_____)**
Social History: **Use of alcohol** Drinks per week_____ **Illegal Drugs** Yes No
Marital History: Married Single Separated Divorced Widowed
Currently sexually active No Yes / **With opposite sex** **Same sex** / **Same Partner** Yes No
History of Domestic Abuse: No Yes explain: _____