



Name: _____ Today's Date: _____
 Date of Birth: _____ Age: _____
 Referred by: Primary Care Provider, Friend, Website, Print Advertisement, Other
 Primary Care Provider: _____ Pharmacy: _____
 Reason for Visit: _____

First Day of Last Menstrual Period: _____

Menstrual History:

Age at first period: _____ Number of days between periods: _____
 Number of days of menstrual flow: _____ Menstrual flow: light, moderate, heavy
 Menstrual cramps: None, light, moderate, severe
 Menopause: Yes No At what age? _____
 Have you used hormone replacement therapy, past or present? Yes No

Gynecologic History:

Prior history of gynecologic conditions such as fibroids, polyps, ovarian cysts, menstrual irregularities, infertility, endometriosis, PMS, breast disease, cancer, other: Yes No If yes, explain: _____

Date of last pap smear? _____ Results: normal, abnormal
 History of abnormal pap smears, colposcopy or treatment of abnormal pap smears: Yes No
 If yes, explain: _____

Sexual History:

Sexually active in past: Yes No Sexually active in present: Yes No
 Number of current partners: _____
 Is sexual activity with: Men, women, both
 Present contraceptive use: _____ Past contraceptive use: _____
 List prior sexually transmitted infections, if any: _____
 Prior history of pelvic inflammatory disease: Yes No
 Have you had the HPV vaccine? Yes (full series? or partial series?) No

Obstetrical History:

Year				
Type of delivery				
Full Term/pre-term				
Gender				
Birth Weight				
Miscarriage/abortion				
Complications				

Breast History:

History of past or current breast cysts, tumors, cancer: Yes No
History of breast biopsies, aspirations, treatments: Yes No
Date of last mammogram, if any: Results:

Bone History:

History of osteopenia or osteoporosis: Yes No
Date of last bone density scan, if any: Results:

Past Medical History:

Medical conditions: None, asthma, heart disease, cancer, diabetes, high blood pressure, thyroid disease, irritable bowel syndrome, other (please list)

Hospitalization and reasons:

Transfusions? Yes No

Colonoscopy: Yes No If yes, when and results:

Past Surgical History:

List all surgeries and dates:

Medications:

List all medications, dosages, and supplements:

Allergies:

Food and drug allergies and indicate the type of reaction to allergies:

Family History:

Family history of medical conditions: Diabetes, heart disease, high cholesterol, cancer, other (please list)

Cancer (list type of cancer and relationship to the family member):

Genetic conditions: Bleeding disorder, sickle cell disease, thalassemia

Social History:

Occupation:

Are you: married, single, in a steady relationship, divorced, separated

Have you been exposed to domestic violence? Yes No

Substance use and quantity: Cigarettes, Alcohol, Drugs

Habits:

Balanced diet emphasizing whole grains, fiber, fruits, vegetables, protein? Yes No

Drink sodas, juices, caffeinated and energy drinks: Yes No

Regular exercise and fitness? Yes No

Average number of hours of sleep per night:

Regular use of seatbelts and helmets? Yes No

Concerns:

Please list any issues or concerns that you would like to discuss today: