



Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____
Referred by: Primary Care Provider, Friend, Website, Other

Primary Care Provider: _____ Pharmacy: _____

Reason for Visit: _____

First Day of Last Menstrual Period: _____

Menstrual History:

Have periods begun? Yes No 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

Gynecologic History:

Do you perceive your pubertal development as normal or different? Yes No
Prior history of gynecologic conditions such a Polycystic Ovary Snyderome, ovarian cysts, endometriosis, Pelvic Inflammatory Disease, other: Yes No
Prior gynecologic care or exams? Yes No When? _____
Prior pap tests: Yes No Results: normal, abnormal
Prior pregnancies? Yes No If yes: resulted in miscarriage, abortion, childbirth

Immunization History:

Childhood vaccinations (including Hepatitis B)? Yes No
HPV vaccine series? Yes No Unknown
If yes, have you completed the series of 3? Yes No
Seasonal flu shot? Yes No

Past Medical History:

Childhood diseases: _____
Hospitalization and reasons: _____
Transfusions? Yes No
Medical conditions: None, asthma, heart disease, cancer, diabetes, high blood pressure, other
History of eating disorder: Yes No
History of mood disorder: Yes No
Prior trauma, accidents, victim of violence? _____

