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Date \_\_\_\_\_

Name \_\_\_\_\_

What do you like to be called? \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

Who is your PCP? \_\_\_\_\_

Pharmacy name and phone #: \_\_\_\_\_

### Past Medical History:

Date of last Pap smear	_____	Ever abnormal? N/Y (Circle) When?	_____	Treatment	_____
Date of last Mammogram	_____	Ever abnormal? N/Y (Circle) When?	_____	Treatment	_____
Date of last Bone density study	_____	Ever abnormal? N/Y (Circle) When?	_____	Treatment	_____
Date of last Colonoscopy	_____	Ever abnormal? N/Y (Circle) When?	_____	Treatment	_____
Date of last cholesterol	_____	Ever abnormal? N/Y (Circle) When?	_____	Treatment	_____

**Check all that apply:**

Asthma	Chlamydia	Genital warts	High cholesterol	Overweight	Stroke
Alcoholism	Deep vein thrombosis	GERD	Hyperthyroid	Pelvic Inflammatory disease	Ulcers
Anemia	Depression	Gonorrhea	Hypothyroid	Rheumatic fever	
Bipolar disease	Diabetes	Heart disease	Irritable bowel	Seasonal allergies	
Anxiety	Drug abuse	Hepatitis	Migraines	Schizophrenia	
Cancer	Genital herpes	High blood pressure	Mitral valve insufficiency	Seizures	

### Past Surgical History:

Operation	Age or Date	Operation	Age or Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### Medications:

Name    Dose    Frequency    Reason you take it

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Herbs, Supplements, Vitamins:

(include aspirin and other over-the-counter remedies)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Allergies:

**None (circle)**

Medication	Effect it has on you
_____	_____
_____	_____

- Circle:
- Eggs
- Nickel
- Adhesive tape
- IV Contrast
- Nuts
- Betadine
- Latex

**\*\*\*PLEASE COMPLETE OTHER SIDE\*\*\***

# Family History

	Living	Deceased	Cause of Death
Father's age	_____	_____	_____
Mother's age	_____	_____	_____
Brothers' ages	_____	_____	_____
	_____	_____	_____
Sisters' ages	_____	_____	_____
	_____	_____	_____

Please list any female family members with gynecologic problems: \_\_\_\_\_

Please check if any of your immediate family members (parents, brothers, sisters, or children ) have or have had any of the following:  
Which Family Member?

- High blood pressure \_\_\_\_\_
- High cholesterol \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Tuberculosis \_\_\_\_\_
- Cancer (what kind) \_\_\_\_\_
- Psychiatric (what diagnosis) \_\_\_\_\_
- Alcohol/Drug abuse (circle) \_\_\_\_\_
- Other \_\_\_\_\_

# Gynecologic History

Date of first day of last menstrual period \_\_\_\_\_ Age at first menstrual period \_\_\_\_\_  
 How long do your periods usually last? \_\_\_\_\_ Do you bleed or spot (circle) between periods? Yes No  
 What is the usual length between periods (cycle length)? \_\_\_\_\_  
 How heavy is your menstrual flow? (circle) Very light Light Moderate Heavy Very heavy  
 Do you experience pain with you periods? (circle) Before During  
 Do you have sex with: (circle) Men Women Both Neither  
 Have you had a new partner in the last year? Yes No  
 Do you presently use anything to prevent pregnancy? Yes No Type \_\_\_\_\_  
 Would you like to be tested for sexually transmitted infections today? Yes No  
 Have you received the Gardasil series? Yes No Partially  
 If menopausal: Age at last menstrual period? \_\_\_\_\_ Current/past (circle) hormone replacement use?  
 Bleeding since last visit? Yes No

# Obstetric History:

Number of term pregnancies \_\_\_\_\_ preterm \_\_\_\_\_ miscarriages \_\_\_\_\_ abortions \_\_\_\_\_ tubal pregnancies \_\_\_\_\_

Date of Delivery / Adoption	Vaginal	Cesarean	Weight	Complications	Name	Age
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

# Social History

Are you: married partnered divorced widowed uninvolved  
 Are you happy with your relationship? Yes No  
 Is there any aspect of your sexuality you'd like to discuss? Yes No  
 Are you presently a cigarette smoker? Yes No Amount per day? \_\_\_\_\_ Are you trying to quit? Yes No  
 Average number of drinks per week (including wine, beer and liquor) \_\_\_\_\_  
 Are you concerned you may be drinking excessively? Yes No  
 Have you ever been or are you currently (circle) physically or sexually (circle) threatened? Yes No  
 Do you exercise regularly? Yes No

What would you like to address with your provider today?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_