



REASON FOR APPOINTMENT \_\_\_\_\_

MARITAL

STATUS:  S  M  D  W  Sep

**MENSTRUAL HISTORY**

Age at first period \_\_\_\_\_ Age at menopause \_\_\_\_\_  
 Bleeding between periods  Yes  No  
 Interval between periods (first day to first day) \_\_\_\_\_  
 Days of flow \_\_\_\_\_

**OBSTETRIC HISTORY**

# of pregnancies \_\_\_\_\_ # of full term deliveries \_\_\_\_\_  
 # of living children \_\_\_\_\_ # of preterm deliveries \_\_\_\_\_  
 # of miscarriages/abortions \_\_\_\_\_ # of ectopic pregnancies \_\_\_\_\_  
 # of adopted children \_\_\_\_\_ Pregnancy complications \_\_\_\_\_

**GYNECOLOGIC HISTORY**

Abnormal pap smears:  Yes  No What? \_\_\_\_\_ When? \_\_\_\_\_ Treatment? \_\_\_\_\_

Have you had any of the following:

Yeast infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bacterial vaginosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trichomoniasis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chlamydia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Syphilis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Genital warts	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you sexually active? \_\_\_\_\_  Yes  No  
 Preference?  Men  Women  Both  Prefer not to discuss  
 Number of sexual partners in the last year? \_\_\_\_\_  
 Have you ever had sexual intercourse against your will? \_\_\_\_\_  Yes  No  
 Any history of physical, mental, or sexual abuse? \_\_\_\_\_  Yes  No  
 Any abuse in current relationship? \_\_\_\_\_  Yes  No  
 Any treatment for emotional/mental illness? \_\_\_\_\_  Yes  No  
 Any pain with intercourse? \_\_\_\_\_  Yes  No

Do you have any concerns with sexual matters that you wish to discuss? \_\_\_\_\_  Yes  No  
 Are you using birth control? \_\_\_\_\_  Yes  No  
 What method? \_\_\_\_\_  
 Any problems with bladder control? \_\_\_\_\_  Yes  No  
 Specify: \_\_\_\_\_  
 Have you ever had a bone scan? \_\_\_\_\_  Yes  No  
 When? \_\_\_\_\_  
 Results? \_\_\_\_\_

**GENERAL HISTORY (History of any of the following for yourself or your family)**

	SELF	FAMILY	WHO		SELF	FAMILY	WHO
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		Alzheimer's	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Type of cancer: \_\_\_\_\_

**MEDICATIONS**

(include prescription, over the counter, herbal and alternative)

**ALLERGIES**

(List all medications, latex, foods)

**LIFESTYLE**

Do you exercise regularly?  Yes  No How much per week: \_\_\_\_\_  
 Do you smoke?  Yes  No How much per day: \_\_\_\_\_  
 Do you drink alcohol?  Yes  No Amount per week: \_\_\_\_\_  
 Do you use street/recreational drugs?  Yes  No Which ones: \_\_\_\_\_  
 Do you drink caffeinated beverage?  Yes  No Amount per day: \_\_\_\_\_  
 Any sleep problems?  Yes  No Specify: \_\_\_\_\_  
 Approximate calcium intake per day \_\_\_\_\_  
 How much stress would you say is in your life? \_\_\_\_\_  
 Do you do monthly self breast exams?  Yes  No

**ALL PAST SURGERIES**

Patient Signature: \_\_\_\_\_

Phone # during office hours: \_\_\_\_\_