PATIENT HISTORY

Date:___/____/20____ **Patient Name:_____ Age:_____**
How did you hear about us?_____
Occupation:_____
Allergies: Medications:_____ Other:_____

Preferred Pharmacy Name:_____ Address:_____ Phone:(_____)____-_____

Medications/Dosage (include prescription, vitamins/supplements, over-the-counter, and "alternative remedies:
_____
_____

GYNECOLOGIC HEALTH & HISTORY

Date your last period began:___/___/___ Date of last PAP Smear:___/___/___ was it NORMAL / ABNORMAL *(circle one)*
How many days from the start of one period to the next?_____ How many days does the flow last?_____
Is the flow?: Light____ Medium____ Heavy____ Very Heavy____ *(check one that applies)*
Age at which you had your first Period?_____ Any Premenstrual symptoms? Yes____ No____
Age you first had intercourse?_____ Are you sexually active?____Yes ____No
Do you have intercourse? Yes____ No____ With Men____ With Women____ Both____
Do you use condoms? Yes____ No____
Birth Control? Yes____ No____ If yes, why type?_____
Age at which you had your first baby?_____
Any Menopausal symptoms? Yes____ No____
Irregular cycles?:____ Vaginal dryness____ Sleep Disturbance____ Hot Flashes____ Other:_____
Age at menopause:_____ Are you taking hormones? Yes____ No____ if yes, Type Dosage?_____
Have you ever had a mammogram? Yes____ No____ Most recent?_____ Results:_____

Medical Problems: Have you ever had in the past or do you currently have (please check):

Abnormal Pap Past ( ) Current ( )	**Blood Clots/DVT** Past ( ) Current ( )	**Cancer** Past ( ) Current ( )	**Eating Disorder** Past ( ) Current ( )	**Heart Murmur** Past ( ) Current ( )	**Infertility Problems** Past ( ) Current ( )	**Migraine Headaches** Past ( ) Current ( )	**Thyroid Problems** Past ( ) Current ( )
Anemia Past ( ) Current ( )	**Blood Transfusion** Past ( ) Current ( )	**Chest Pain** Past ( ) Current ( )	**Fibroids** Past ( ) Current ( )	**Hepatitis A/B/C** Past ( ) Current ( )	**Kidney Disease** Past ( ) Current ( )	**Seizures** Past ( ) Current ( )	**Tuberculosis** Past ( ) Current ( )
Asthma/Lung Disease Past ( ) Current ( )	**Bowel Disease** Past ( ) Current ( )	**Depression/ Anxiety** Past ( ) Current ( )	**Gonorrhea / Chlamydia** Past ( ) Current ( )	**HIV/AIDS** Past ( ) Current ( )	**Kidney Infection** Past ( ) Current ( )	**Stomach Problems/Ulcer** Past ( ) Current ( )	**Urine Leakage** Past ( ) Current ( )
Arthritis Past ( ) Current ( )	**Breast Lump** Past ( ) Current ( )	**Diabetes** Past ( ) Current ( )	**Heart Disease** Past ( ) Current ( )	**Hypertension** Past ( ) Current ( )	**Liver Disease** Past ( ) Current ( )	**Syphills** Past ( ) Current ( )	**Venereal Disease** Past ( ) Current ( )

Hospitalizations or Operations

Year	Diagnosis/Operation	Hospital

OBSTETRIC HEALTH & HISTORY

Pregnancies: Total number:_____ Miscarriages:_____ Abortions:_____ # Living Children:_____

Mth / Yr	Hrs in Labor	C section/Vag	Infant Weight	Sex	How far along	Problems / Complications

FAMILY HISTORY

(Please list any medical problems in your family)

Patient Name:_____ DOB:____/_____/_____

Mother=M Father=F Child=C Maternal Grandmother=MM Maternal Grandfather=MF
Paternal Grandmother=PM Paternal Grandfather=PF Aunt=A Uncle=U Sibling=S

	Yes	*No*	*List Family*		*Yes*	*No*	*List Family*		*Yes*	*No*	*List Family*
Diabetes				Heart Disease				Heart Attack			
Stroke				Hypertension				High Cholesterol			
Uterine Cancer				Ovarian Cancer				Breast Cancer			
Colon Cancer				Other Cancer				Arthritis			
Osteoporosis				Menopause < age 40				Twins			
Birth Defects				Alcohol/Drug Abuse				Psychiatric illness			
Other				List if Yes:							

	Living				
	Yes	**No**	**Age** ***(or age at death)***	**Medical Problems**	
Mother					
Father					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					
Siblings					

Have you ever been tested for HIV? Yes____ No____ When?_____
What is your mental image of your body?(Plump, thin, normal?)_____ Ideal Weight?_____
Have you ever been diagnosed with an eating disorder or feel you have an eating problem? Yes____ No____
Are you on any diet restrictions or have any special diet preferences?_____
What is your stress level on a 1-10 scale?_____ What do you do to relieve stress?_____

SOCIAL HISTORY

Ethnicity:_____ Religion:_____
Single_____ Married_____ Widowed_____ Divorced_____ Life Partner_____
Caffeine use: None_____ Cups per day_____ How long?_____ Want to Quit? Yes____ No_____
Type of Caffeine:_____
Tobacco use: None_____ Packs per day_____ How long?_____ Want to Quit? Yes____ No_____
Alcohol use: None_____ Drinks per day_____ Per week_____ Per month_____
Exercise:____Yes ____No: if yes what type and for how long?:_____
Would you agree to a blood transfusion?____Yes ____No
Do you have pets:____Yes____No: What kind of pets?_____ Do you clean up after your pet?_____
Street Drug use: None_____ Drug_____ How often?_____
Have you been in an abusive situation or relationship? Yes_____ No_____ Emotional_____ Physical_____ Sexual_____
Do you feel safe in your current relationship? Yes_____ No_____
Do you wear your seatbelt? Yes_____ No_____
Do you have firearms in your home? Yes_____ No_____
Can we answer any questions or provide material about any health or gynecologic health concern?
_____
_____