NAME ______________________ **DATE OF APPT** ______________________

AGE ______________________

BIRTH DATE ______________________ **PCP** ______________________

PREFERRED PRONOUN **SHE/HER** **HE/HIM** **THEY/THEM** **REFERRED BY** ______________________

OCCUPATION ______________________

REASON FOR VISIT ______________________

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GYNECOLOGIC HISTORY

Onset of last period ______________

Age at first period ______________

How many days do you bleed? ______________

Length of cycles (days between periods) ______________

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	yes	*no*
Are your periods painful?		
Any bleeding between periods?		
Any bleeding after intercourse?		
Any vaginal itching or abnormal discharge?		

Any history of recurrent (circle) Bacterial vaginosis Yeast

If you are menopausal

At what age did you stop menstruating?		
Have you ever taken hormones?		
Are you taking hormones now?		

HEATH CARE MAINTENANCE

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Date of last pap smear ______________

Was it (please circle) Normal Abnormal

If Abnormal, please list treatment/date ______________

Have you ever had:

	yes	*no*
An abnormal pap? If yes, when ___________		
Cryotherapy/Biopsy/Laser/LEEP (circle)		
Human Papillomavirus (HPV)		
The HPV vaccine		
Have you ever had a mammogram (date)		
Have you ever had a colonoscopy (date)		
Have you ever had a DEXA bone scan (date)		

When did you last have your cholesterol checked? (date) ________

SEXUAL HISTORY

	yes	no
Are you sexually active?		
with men / with women (please circle)		
oral / genital / anal / other (please circle)		
Have you ever had an STD?		
If yes, circle: Herpes (oral/genital) Gonorrhea Chlamydia Syphilis HIV		
Any history of Hepatitis?		
Would you like an STD screen today?		

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Number of partners in the last 5 years 0 1 2-5 >5

	yes	no
Do you currently use birth control?		
What do you use? ____________		
Are you satisfied with this method?		
Are you currently trying to get pregnant?		
If yes, for how long? ____________		

What have you used for birth control in the past?
Please circle: Condoms IUD Pill Nuvaring
Implant Patch Diaphragm

OBSTETRICAL HISTORY

___ Check here if never pregnant

Are you currently pregnant? [ ] [ ]

If yes, date of LMP ____________

Have you had infertility treatment? Where? ____________

Please describe ____________

#	Date	Pregnancy Outcome (miscarriage, vag del C/S)	Length (wks)	Epidural?	Gender	Weight	Hospital	Complications?
1								
2								
3								
4								
5								

UROLOGIC HISTORY

	yes	no
Do you lose urine with cough/sneeze		
Do you have a history of bladder infections		
History of kidney infections?		

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SURGICAL HISTORY

Year	Surgical Procedure

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MEDICAL HISTORY

Have you ever had:	yes	no	for doctors use only
Depression			
Anxiety			
Eating disorder			
Migraine headaches with aura			
Thyroid disorder			
High blood pressure			
High cholesterol			
Heart disease			
Echocardiogram			
Breast lump evaluated?			
Asthma			
Deep Vein Thrombosis (DVT)			
Pulmonary Embolism (PE)			
Stomach ulcers			
Intestinal problems			
Gallstones			
Diabetes			
Kidney problems			
Liver problems/hepatitis			
Blood transfusion			
Cancer			
Autoimmune disorder			
Osteoporosis			

Other Medical History: ______________________________

FAMILY HISTORY

Have any relatives had: (Who?/age at dx)	yes	no	
Breast cancer			
Ovarian cancer			
Colon cancer			
Heart attack			
Stroke			
High blood pressure			
Diabetes			
Birth defects			
Reaction to anesthesia			
Kidney disease			
Liver disease			

Other ______________________________

SOCIAL HISTORY

Are you (circle): Single In a relationship Married Partnered Divorced Other

Occupation ______________________________

Do you:

	yes	no
Smoke tobacco products		
Drink alcohol; circle drinks per week 0 1-5	5-10	>10
Use Marijuana or take other recreational drugs		
Wear your seatbelt		
Have a history of abuse		
Suffer ongoing abuse		
Feel safe		
Exercise regularly		
Have guns in the home?		
If so, are they secured?		

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REVIEW OF SYSTEMS

Do you currently have any of the following symptoms (please circle)

Body aches
Fatigue
Night sweats
Impaired vision
Headaches
Breast lumps
Nipple tenderness or discharge
Chest pain
Fainting
Irregular heart beat

Shortness of breath
Cough
Wheezing
Nausea/Vomiting
Diarrhea
Constipation
Blood in stools
Urinary incontinence
Pain with urination
Skin rash

Numbness
Joint pain
Heat/cold intolerance
Depression
Anxiety
Easy bleeding or bruising (circle which)
Seasonal allergies

MEDICATIONS

Please list current medications, doses, instructions

____

____

____

____

____

____

____

____

MEDICATION ALLERGIES (and reaction)

____

____

____

____

Anything else we should know to help us in your care?

____

PATIENT SIGNATURE ______________________________ **DATE** ______________