

Your Name: _____ Date of Birth: ___/___/___ Today's Date: ___/___/___

Reason for today's visit: _____

Preferred Pharmacy Name/City: _____ Preferred Lab for testing: _____

MENSTRUAL HISTORY

Date of your last menstrual period _____ Do you have menstrual cramps? No Yes

What age did you have your first period? _____

Are you post-menopausal No Yes If yes, at what age? _____

Have you had a hysterectomy? No Yes If yes, what year? _____ Type _____

SEXUAL ACTIVITY

Are you sexually active? No Yes Partner Gender: Male Female

CONTRACEPTION

What is your current method of birth control: _____

Are you satisfied with your current method? No Yes Do you want to change? No Yes

Are you thinking of conceiving in the next year? No Yes

GYNECOLOGIC HISTORY

Date of your last Pap Smear _____ Was it normal? No Yes

Have you ever had an abnormal pap smear? No Yes What year? _____

What was the result? _____

Have you ever had a colposcopy for an abnormal pap smear? No Yes

Have you had treatment for abnormal pap smear? No Yes

If yes, what treatment and when: _____

Date of your last Mammogram (40+) _____

Have you ever had an abnormal mammogram? No Yes

Have you ever had breast implants? No Yes When: Current Past (removed)

Implant Type: Silicone Saline

Do you perform regular breast self examinations? No Yes

Date of your last Dexa/bone scan (65+) _____

Date of your last Colonoscopy (50+) _____

SOCIAL HISTORY

Tobacco Use: Never smoked Current smoker Former smoker Smokeless tobacco use: No Yes

Do you smoke cigarettes: No Yes If yes, _____ amt/day for how long? _____

Ready to quit? No Yes

Do you drink alcohol: No Yes If yes, _____ drinks a day a week

Recreational drug use: No Yes for how long? _____ Former user? No Yes

Type: Marijuana Methamphetamine Ecstasy Heroin Cocaine IV Prescription Drug

Have you been a victim of abuse or domestic abuse? No Yes
 If you have firearms in your home, are they locked up? No Yes N/A

PREGNANCY HISTORY

How many times have you been pregnant? _____ How many children do you have? _____
 How many were deliveries were _____ vaginal _____ cesarean sections _____ VBAC
 How many pregnancies were _____ miscarriages _____ abortions _____ ectopic

Month/Year	Birth Weight	Sex	Weeks Pregnant	Type of Birth	Complications

MEDICAL HISTORY- Circle all that apply for past or present conditions None

- | | | |
|---------------------------------------|--------------------------|------------------------------|
| Abnormal Uterine Bleeding | Endometriosis | Obstructive Sleep Apnea |
| Alcohol Abuse | Fecal Incontinence | Pain with intercourse |
| Alzheimer’s | Fibroids | Pelvic Inflammatory disease |
| Anemia | Genital warts | Polycystic Ovary Syndrome |
| Anxiety | Gonorrhea | Problem with periods |
| Aortic Stenosis | Heart attack | Pulmonary Embolism |
| Arthritis | Herpes | Renal Insufficiency or |
| Atrial fibrillation | Hepatitis B | Recurrent Bladder Infections |
| Asthma | Hepatitis C | Seizure Disorder |
| Birth Defects | High blood pressure | Sexual Problems |
| Cancer Type: _____ | High cholesterol | Sexually Transmitted Disease |
| Chlamydia | HIV | Stroke |
| Chronic Obstructive Pulmonary Disease | HPV | Syphilis |
| Congestive heart failure | Infertility | Tuberculosis |
| Coronary artery disease | Irritable Bowel Syndrome | Ulcers or H pylori |
| Dementia | Kidney Problems | Urinary Incontinence |
| Depression | Leukemia | Uterine cramps |
| Diabetes treated with insulin | Low thyroid | Uterine Fibroids |
| Diabetes treated with pills | Obesity | Other: _____ |
| Deep Vein Thrombosis/blood clot | Osteoporosis | |

FAMILY HISTORY

unknown/adopted

List any medical conditions that your family has:

Mother: _____

Father: _____

Sister: _____

Sister: _____

Brother: _____

Brother: _____

Any other family member with: *Please state relationship (example, maternal aunt, paternal grandmother)*

Breast Cancer: _____

Ovarian Cancer: _____

Colon Cancer: _____

SURGICAL HISTORY

None

	Year		Year		Year
Tonsillectomy	_____	Appendectomy	_____	D&C (miscarriage)	_____
Cardiac Catherizaton	_____	Tummy tuck	_____	D&C (bleeding)	_____
Heart Surgery (CABG)	_____	Gastric bypass	_____	Hysterectomy	_____
Breast biopsy	_____	Colonscopy (polyp)	_____	Myomectomy	_____
Breast implants	_____	laparoscopy	_____	Uterine ablation	_____
Abdominal Surgery	_____	C-section	_____	LEEP/Cone biopsy	_____
Hernia repair	_____	Tubal ligation	_____	Other:	_____

List any drug allergies:

None

Name	Reaction

Name	Reaction

Please list any prescribed medications you are currently taking:

None

Name	Dose

Name	Dose

Please list any non-prescribed/over the counter medications you are currently taking:

None

Name

Name