

Name _____ SS# _____ Date _____

Date of Birth _____ Age _____ Race _____ Marital Status _____

General Information

What is the purpose of your visit today? _____ Do you have a doctor for other medical care? Yes No

Have you ever had a pelvic exam? Yes No Do you eat healthy? Yes No Do you exercise regularly? Yes No

Are you allergic to any medications, metals, or iodine? Yes No Type of Exercise _____

List: _____ Amount Per Week _____

Are you presently taking medication (prescription or over-the-counter) vitamins or herbal supplements? Yes No

List: _____

In a typical week, how often do you: Use alcohol _____ times a week. Use street drugs/marijuana _____ times a week.

How many cigarettes/cigars do you smoke? _____ per day How many years have you smoked _____

Have you ever quit smoking? Yes No Do you want to quit now? Yes No

How many cups of beverages containing caffeine do you drink a day _____

Menstrual / Pregnancy / Sexual History

Age periods began _____

First day of last normal period _____

Number of days between day 1 of period & day 1 of next period _____

Number of days you flow _____

Is your flow Light Medium Heavy

Number of pads or tampons used per day _____

Do you experience cramps? Yes No

Are you currently sexually active? Yes No

My sexual partner(s) are Male Female Both

Have any of your partner(s) used IV drugs? Yes No Unknown

Have any of your partner(s) had any blood transfusions? Yes No Unknown

Have you ever had sex with a man who has had male-to-male sexual contact? Yes No Unknown

Your current types of intercourse are: Vaginal Anal Oral

Number of sexual partners: Now _____

Last 12 months _____

Lifetime _____

Age of your first intercourse _____

Are you currently pregnant? Yes No

If so, is this your first pregnancy? Yes No

Age at first pregnancy _____

Any problems with pregnancies (i.e. toxemia (high blood pressure), diabetes, genetic abnormalities, etc.)? Yes No

Specify: _____

List the total number of times pregnant _____

Number of live births _____

Date(s) _____

Number of living children _____

Number of premature births _____

Number of vaginal deliveries _____

Number of C-sections _____

Number/Date(s) of abortions _____

Number/Date(s) of miscarriages _____

Number/Date(s) of still births _____

Number/Date(s) of ectopic (tubal) pregnancies _____

Date(s) _____

Do you want children in the future? Yes No Unsure

Are you currently breast feeding? Yes No

Contraceptive History

In the past, what birth control methods have you used?

- pill sponge withdrawal / pull-out norplant vasectomy
 condoms diaphragm natural / rhythm depo provera none
 spermicide / foam cervical cap IUD type: _____ tubal ligation other _____

Any problems with methods used? _____

What method of birth control do you want to use now? _____

Pill names and dates: _____ Depo Provera dates: _____

Do you currently have or have you ever had the following? (check all that apply)

- 1. frequent vaginal infections
- 2. infection in uterus / tubes / ovaries
- 3. sexually transmitted infection:
 - chlamydia gonorrhea syphilis warts
 - hepatitis B crabs herpes trich
- 4. missed periods
- 5. bleeding between periods
- 6. uterine tumors / ovarian cysts
- 7. uterine abnormality
- 8. abnormal pap smears
- 9. sexual problems
- 10. urinary tract infections
- 11. ob / gyn / surgery (laparoscopy, colposcopy, etc.)
- 12. mother took DES hormones while pregnant with you
- 13. breast problems / surgery
- 14. mental / emotional problems / depression
- 15. numbness / tingling in arms or legs
- 16. seizures / fainting spells / epilepsy
- 17. severe headaches / migraines
- 18. vision problems
- 19. problems w/sexual abuse, domestic violence, or sexual coercion
- 20. thyroid disease
- 21. high blood pressure
- 22. high blood fat levels / cholesterol
- 23. anemia-type if known: _____
- 24. heart problems / murmurs / rheumatic fever / stroke
- 25. respiratory problems / asthma
- 26. tuberculosis
- 27. inflammation of veins / blood clots
- 28. varicose veins
- 29. stomach / intestinal problems
- 30. gall bladder disease
- 31. kidney / bladder disease
- 32. hepatitis / mono / jaundice / liver disease
- 33. hepatitis B vaccination
- 34. blood transfusion
- 35. diabetes / "sugar"
- 36. German measles or vaccine
- 37. cancer
- 38. genetic problems / birth defects
- 39. overweight / underweight
- 40. hospitalization / surgery
- 41. problems with balance, hearing, taste, smell
- 42. other medical problems:

My last medical check-up was:
 Date: _____
 Reason: _____
 My last pap test was:
 Date: _____
 Results: _____
 Notes: _____

Personal History

Family History

Have your birth parents, brothers or sisters ever had the following?

- diabetes
- cancer
- stroke
- high blood pressure
- heart attack before age 55 (males) / 65 (females)
- high blood fat levels (cholesterol)
- arthritis
- osteoporosis

- deep vein thrombosis (blood clots) or pulmonary embolism
- broken bones after age 35
- don't know / unsure
- adopted
- _____

To the best of my knowledge, the above information is complete and accurate.
 All information you have given us will be confidential. No information will be released without your consent.

Date: _____
 Patient Signature: _____

Date: _____
 Clinician Signature: _____

Annual Review Date: _____ LMP: _____

Notes: _____

Patient Signature Clinical Signature

Annual Review Date: _____ LMP: _____

Notes: _____

Patient Signature Clinical Signature