Date_____

Name_____ DOB_____

Reason for today's appointment_____

Medications:	Allergies:

GYN History:

Age at first period: _____

Date of last menstrual period: _____

Last menstrual period: Unknown/Approximate/Definite

Do you have monthly periods? Yes No

Flow: Light/Moderate/Heavy   How many days does your period last? _____

Painful periods? Yes No   Bleeding between periods? Yes No

Are you menopausal? Age at menopause _____

Are you taking Hormone Therapy?   Yes   No

Any bleeding after menopause? Yes   No

Are you currently sexually active? Yes No   Do you have sex with: Men Women Both

# of lifetime sexual partners ____   Are you currently safe at home? Yes No

Painful sex? Yes No

Have you ever had a STD/STI? Yes No _____

Have you received the HPV Vaccine   Yes No

Have you ever had an Abnormal Pap smear? Yes No

Current birth control method _____

Past birth control methods_____

What % of the time do you use condoms? _____

Date of your most recent Pap smear	
Date of your most recent Mammogram	

Date of your most recent Bone Density	
Date of your most recent Colonoscopy	

Surgical History:

Procedure	Date

Obstetric History:

How many total pregnancies have you had? _____

Full Term deliveries _____Premature deliveries _____ Abortions_____ Miscarriages _____ Ectopic_____

Did you ever have twins or triplets? _____

How many living children do you currently have? _____

Past Pregnancies:

| Date of delivery | # of weeks | Baby's weight | Type of Delivery | Gender/name, |

problems?

_____

_____

_____

_____

_____

Family History: Please indicate which relative:

DVT/PE	
Stroke	
Diabetes	
Thyroid problem	
Heart disease	
High cholesterol	
Heart attack	

Breast cancer	
Cervix cancer	
Colon cancer	
Lung cancer	
Ovarian cancer	
Uterine cancer	
Osteoporosis	

Social History:

Are you currently employed? _____occupation_____

Education_____relationship status_____

Have you ever been a victim of physical/sexual abuse? _____

How much do you exercise? _____

Smoking Status Never/Former/occasional smoker/everyday smoker

Caffeine intake Yes No

Recreational drugs? Never/Current/Past Drug of choice_____

Alcohol use? None/occasional/moderate/heavy how much? _____ how often? _____

Is blood transfusion acceptable in an emergency? Yes   No   Do you have advance directives? Yes   N

How much do you smoke? _____
How many years have you smoked

Past Medical History: Please check if you have now or have ever had any of the following problems.

	Yes	No
Migraine with flashing lights		
Migraine headache		
Blood clots (DVT/PE) in legs, arms or lungs		
Factor V Leiden / Prothrombin		
Lupus		
Antiphospholipid antibody syndrome		
Epilepsy / seizure disorder		
High blood pressure		
High cholesterol/triglycerides		
Heart attack		
Heart rate irregularities/arrhythmia		
Stroke		
Heart disease		
Mitral valve prolapse or Aortic stenosis		
Asthma		
COPD		
Sleep apnea		
Tuberculosis		
Dermatology disorder		
Malabsorption (Celiac, gastric stapling/surgery)		
Fibromyalgia		
Multiple sclerosis		
Acid reflux/GERD		
Gallstones		
Pancreatitis		
Alcoholic hepatitis		
Hepatitis A, B or C		
Cirrhosis		
Irritable bowel syndrome		
Crohn's or ulcerative colitis		
Kidney failure/insufficiency		
Diabetes		
Hypothyroid		
Hyperthyroid		
Hashimoto's thyroiditis		
Graves' Disease		
Osteopenia		
Osteoporosis		

	Yes	No
Arthritis – osteoarthritis		
Arthritis - rheumatoid		
PCOS / Metabolic syndrome		
Depression (Postpartum Depression) / Anxiety		
Bipolar disorder		
Mental illness /Schizophrenia		
Cervix cancer/dysplasia		
Breast cancer		
Fibrocystic breasts/Benign breast disorder		
Uterine cancer		
Ovarian cancer		
Melanoma		
Basal or squamous cell skin cancer		
Thyroid cancer		
Lymphoma/Leukemia		
Overactive bladder		
Leaking urine		
Recurrent bladder infections		
Interstitial cystitis/painful bladder		
BRCA carrier positive		
LYNCH syndrome carrier positive		
Cystic fibrosis carrier		
Genetic / inherited problem		
Cerebral palsy		
Developmental delay		
Anemia/Sickle cell/ thalassemia		
Neural tube defect / spina bifida		
HIV		
Herpes genital		
Herpes oral		
Syphilis		
PID		
Endometriosis		
Uterine hyperplasia		
Fibroids		
Ovarian tumors/cysts		
Infertility		
Recurrent pregnancy loss		
History of a blood transfusion		
Complications with anesthesia		