

1. Patient Identification (Please Print)

Patient's name: _____ Date of Birth: _____ Age: _____
 Address: _____ Marital Status: _____

 Home Telephone Number: _____ Employer: _____
 Work Telephone Number: _____ Occupation: _____
 Message Telephone Number: _____ Referring Physician: _____

2. Reason For Seeing Doctor:

3. Medical History

Have you or any members of your family had:

- | | |
|---|--|
| High Cholesterol.....[] you [] family | Blood Transfusion.....[] you |
| Heart Disease.....[] you [] family | Allergies.....[] you |
| Rheumatic Fever.....[] you | Breast Problems.....[] you [] family |
| High Blood Pressure.....[] you [] family | Cancer.....[] you [] family |
| Asthma.....[] you | Infertility.....[] you |
| Tuberculosis.....[] you | Female or Sexual Problems.....[] you |
| Diabetes.....[] you [] family | Chlamydia.....[] you |
| Thyroid Problems.....[] you [] family | Gonorrhea.....[] you |
| Liver Disease.....[] you | Herpes (HSV)[] you |
| Stomach, Bowel, or | Syphilis.....[] you |
| Gall Bladder Problems.....[] you | Birth Defects or |
| Kidney or Bladder Problems.....[] you | Inherited Diseases.....[] you [] family |
| AIDS (HIV).....[] you [] family | Other Medical Problems....[] you [] family |
| Hepatitis (type ____).[] you [] family | |
| Anemia or Blood Disorder.....[] you [] family | |

4. Hospitalizations (not including childbirth)

| Month/Year | Illness or Operation | Attending Physician | Complications |
|------------|----------------------|---------------------|---------------|
| | | | |
| | | | |
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| | | | |
| | | | |

5. Pregnancy History

| # of Pregnancies | | # of Premature Births | | # of Miscarriages | # of Induced Abortions | | # of Living Children | Complications |
|------------------|-----------------|-----------------------|-----------------|------------------------------|------------------------|------------------|----------------------|---------------|
| # of term births | Born month/year | Baby's sex | Weight at Birth | Weeks Pregnant (term 40 wks) | Hours in Labor | Type of Delivery | Type of Anesthesia | |
| 1 | | M F | | | | | | |
| 2 | | M F | | | | | | |
| 3 | | M F | | | | | | |
| 4 | | M F | | | | | | |
| 5 | | M F | | | | | | |
| 6 | | M F | | | | | | |
| 7 | | M F | | | | | | |

6. Please answer the following questions by putting an (X) in the box next to the word Yes or No, except where you are asked for specific information.

If a question doesn't apply, skip it and go on to the next one.

Menstruation If you have not yet begun to menstruate, please begin with question 12.

1. How old were you when you first began menstruating? years old
2. What was the first day of your last menstrual period?
3. Are you past your menopause, or have you had a Hysterectomy? [] yes [] no
4. If Yes: Have you noticed any vaginal bleeding since? [] yes [] no
(Please skip to question 12)
5. Was your last menstrual period normal? [] yes [] no
6. How many days pass between the first day of each period? days pass
7. How long do your periods last? days
8. On your heaviest day, how many pads and/or tampons do you use? pads tampons
9. Are your periods usually painful? [] yes [] no
10. If Yes: Is the pain generally mild, moderate or severe? [] mild [] moderate [] severe
11. How do you treat your pain? Treat with

Gynecology

12. Do you examine your breasts at least once a month? [] yes [] no
13. Have you noticed any discharge from your breasts? [] yes [] no
14. Have you noticed any change in the size of your breasts? [] yes [] no
15. Have you noticed any lumps or pain in your breasts? [] yes [] no
16. Have you ever had a mammogram? [] yes [] no
17. If yes: Write the month and year of your last test?
18. Have you had recurrent bladder infections? [] yes [] no
19. Are you bothered by frequent or painful urination? [] yes [] no
20. Do you have recurrent middle back pain? [] yes [] no
21. Have you had any recent vaginal itching or discharge? [] yes [] no
22. Have you ever had any infection in your tubes or ovaries? [] yes [] no
23. Have you ever had a Pap Smear? [] yes [] no
24. If Yes: Write in the month and year of your last test.....
25. Have you ever had abnormal results from a Pap Smear? [] yes [] no
26. Did your mother ever take DES or any other hormones when she was pregnant with you? [] yes [] no
27. Are you currently sexually active? [] yes [] no
28. If Yes: Do you have one or many partners? [] one [] many
29. Do you have pain with intercourse? [] yes [] no
30. Do you use birth control on a regular basis? [] yes [] no
31. What form of birth control have you and your partner used?..... [] oral type [] Depo Inj
[] Lunelle Inj [] IUD [] Diaphragm
[] Norplant [] Condoms
32. Do you have any questions about birth control? [] yes [] no
33. Have you ever had complications with any type of birth control? [] yes [] no
34. Do you have any questions about sexually transmitted diseases? [] yes [] no
35. Have you ever had any difficulty getting pregnant? [] yes [] no

Medications Now Taking Are you taking any of the following:

36. Antibiotics..... [] yes [] no
37. Penicillin..... [] yes [] no
38. Sulfa Drugs..... [] yes [] no
39. Aspirin..... [] yes [] no
40. Codeine/Demerol/Other pain medicine..... [] yes [] no
41. Sedatives/tranquilizers..... [] yes [] no
42. Birth Control Pills..... [] yes [] no
43. Estrogen..... [] yes [] no
44. Other Hormones..... [] yes [] no
45. Blood Pressure medicines..... [] yes [] no
46. Other medicines/vitamins..... [] yes [] no
47. Are you allergic to or do you react poorly to any medicines? [] yes [] no
48. Are you a habitual user of any medicines or drugs? [] yes [] no

Please list any medications you are currently taking (include strength and dosing instructions) :

Substance Use:

50. Do you smoke cigarettes?[] yes [] no
51. If yes: How many packs per day do you smoke?.....
52. Do you drink alcohol?[] yes [] no
52. If yes: How much alcohol do you consume in a week?.....
53. How much caffeine do you consume in a typical day?.....
54. Do you take any street drugs?[] yes [] no
55. If yes: What type of street drug do you use?.....
56. How much do you use in a day?.....

General Systems Review:

57. Do you have severe headaches more than once a week?[] yes [] no
58. Have you noticed any unusual hair growth or loss?[] yes [] no
59. Have you noticed any blood in your stools?[] yes [] no
60. Do you feel nervous or anxious on a daily basis?[] yes [] no
61. Do you feel lonely or depressed?[] yes [] no
62. Do you frequently have trouble sleeping?[] yes [] no
63. Are you concerned about work or family problems?[] yes [] no
64. Have you ever been treated for depression?[] yes [] no

Patients Signature: _____

Date: _____