PATIENT INFORMATION:

Name:_____ DOB:_____
Referring MD:_____
Primary Care Physician:_____
Visit Information:
Do you have any concerns you would like to discuss with me today? If so, please describe below:

Medication/Supplements:

Allergies to Medications/Foods:	**Type of Reaction:**

Gynecological History:
Last Menstrual Period: _____ Age of first menstruation: _____
How often is your period? _____ How long does it last? _____
Problems with your period? _____
History of abnormal pap smears? _____
If yes, please describe treatment: _____
Last pap smear_____Last Mammogram_____
History of pelvic infections? _____
What are you using for contraception? _____

Obstetrical History:
How many times have you been pregnant? ____Please list year, type of delivery/intervention/complications:

Year	Type of Delivery	Interventions	Complications	Name

Medical History:
Do you have any health problems/hospitalizations that I need to know about? Yes/No
If yes, please list them below:

Year	Diagnosis

Surgical History:
Have you had any surgery? Yes/No
If yes, please list type and if you experienced any complications:

Year	Procedure

Family History:
Are there any health problems in your family, ***especially breast, ovarian, uterine or cervical cancers***, ***heart disease,*** *or* ***hypertension?*** Please note mother or father's side of the family.

Family Member	Age	Diagnosis

Social History:
Marital status:_____ Occupation:_____Milk products/day:___
Do you use tobacco products? Yes/No If yes, how long and how much? _____
Do you use recreational drugs? Yes/No If yes, what kind? _____
Do you drink alcohol? Yes/No If yes, what kind and how often? _____
Do you have a history of domestic or sexual abuse? Yes/No
Do you exercise? Yes/No If yes, how much/what type? _____
How many **lifetime** sexual partners have you had? Male_____Female_____
Are there any partner issues you need to talk about today? Yes/No_____

Review of Systems: If you have any of the following, please select from the drop down.

Ear/Nose/Throat				
Lungs				
Heart				
Back				
Breast				
Bowels				
Bladder				
Sexual				
Psychiatric				

Other Comments: _____
_____
_____