

Please complete the following information as accurately as possible. Your answers on this form will help your provider understand your medical concerns and conditions better. If you cannot remember specific details, please give best estimates.

G ___ P ___ A ___ LC ___ OFFICE USE ONLY

Name _____ Age _____ DOB _____ Date _____

Date of Last Period _____

Current Method of Birth control _____

Are you interested in being tested for sexually transmitted infections: YES ___ NO ___

Are you interested in receiving the HPV Vaccine: YES ___ NO ___

1. Current Medications: Prescription and non-prescription medicine, vitamins, home remedies, birth control pills, herbs

	Dosage (mg)	Frequency	Date Started	Prescribing physician

2. What is the reason for your visit?

3. Present health concerns; additional problems:

4. Menstrual History:

Age at first period: _____ Are your periods: ___light ___moderate ___heavy
 Length of each period: _____ Do you have cramps? ___No ___Mild ___Moderate ___Severe
 Do you have concerns about your period? ___ Yes ___ No
 Do you have symptoms of menopause? ___ Yes ___ No
 Frequency of Periods: _____
 1st day (date) of most recent period: _____

5. Past Medical History (check all boxes that apply)

How would you rate your general health: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent		
Mammogram	Date: _____	Results: _____
	Ever Abnormal? <input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Papsmear	Date: _____	Results: _____
	Ever Abnormal? <input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Please indicate whether you have had any of the following medical problems and when (dates):		
<input type="checkbox"/> Alcoholism _____	<input type="checkbox"/> Heart Attack _____	
<input type="checkbox"/> Bleeding/Clotting Problems _____	<input type="checkbox"/> Heart Disease _____	
<input type="checkbox"/> Blood Transfusion _____	<input type="checkbox"/> High Blood Pressure _____	
<input type="checkbox"/> Cancer (Malignancy) _____	<input type="checkbox"/> High Cholesterol _____	
Specific Type _____	<input type="checkbox"/> Thyroid Problems _____	
<input type="checkbox"/> Depression/Suicide Attempt _____	Specific Type _____	
<input type="checkbox"/> Diabetes _____		
List Others: _____		

6. Please list any surgeries, illnesses or new medical problems since your last visit

Date	Illness or Operation	Complications

7. Allergies (Drug, Food, Environment)

Allergies (Drug, Food, Environment)	Reactions

8. Family History

Please indicate below significant medical problems of family members. Indicate which family members by checking the appropriate column.

	Mother	Father	Brother	Sister	Grandmother (Maternal)	Grandmother (Paternal)	Grandfather (Maternal)	Grandfather (Paternal)	Aunt	Uncle
Arthritis										
Blood Clots										
Breast Cancer										
Cervical Cancer										
Diabetes										
Elevated Cholesterol										
Heart Disease										
High Blood Pressure										
Ovarian Cancer										
Stroke										
Other Cancer (not mentioned)										
Other Disease (not mentioned)										
Osteoporosis										
Uterine Cancer										

9. Social History

Occupation	What is your current occupation?		
Marital Status	<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Remarried <input type="checkbox"/> Single <input type="checkbox"/> Widowed		
Sexual Activity	Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not currently Current Sex Partner(s) is/are: <input type="checkbox"/> Male <input type="checkbox"/> Female Have you had more than 4 sexual partners in your life time? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had any sexually transmitted diseases (STDs)? <input type="checkbox"/> Yes <input type="checkbox"/> No Partner's Name: _____ Partner's Occupation: _____		
Alcohol Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drinks per week: _____	Is alcohol use a concern for you or others? <input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco Use	Cigarettes? <input type="checkbox"/> Never <input type="checkbox"/> Quit, Date: _____ <input type="checkbox"/> Current Smoker, Packs per day _____ Number of years: _____ Other tobacco: _____ Are you interested in quitting smoking? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Safety	Do you use seat belts consistently? <input type="checkbox"/> Yes <input type="checkbox"/> No Is violence at home a concern for you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Drug Use	Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No		

10. OB History

Summary of Previous			Full Term		Premature		Abortions/Miscarriages			Now Alive	
	DOB	Hospital	Weeks Gestation	# Hrs in labor	Vaginal or C-Section	Sex	Birth Weight	Mother's Total Weight Gain	Rhogam Injection	Mother	Infant
1											
2											
3											
4											
5											
6											

11. Review of Body Systems: (check all that are applicable and explain if needed)

Constitutional	<input type="checkbox"/> Chills <input type="checkbox"/> Excessive urination <input type="checkbox"/> Fever <input type="checkbox"/> Weight gain <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Fatigue <input type="checkbox"/> Night sweats <input type="checkbox"/> Weight loss
Eyes	<input type="checkbox"/> Recent changes in vision
H.E.N.T. (Head, ears Nose & Throat)	<input type="checkbox"/> Hay fever or allergies <input type="checkbox"/> Problems with teeth and gums <input type="checkbox"/> Sinus pain/congestion
Cardiovascular	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations
Respiratory	<input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing
Gastrointestinal	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Blood in stools <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting <input type="checkbox"/> Bloating <input type="checkbox"/> Constipation <input type="checkbox"/> Nausea
Genitourinary/Gynecological	<input type="checkbox"/> Frequency <input type="checkbox"/> Incontinence <input type="checkbox"/> Sexual Dysfunction <input type="checkbox"/> Hematuria (blood in urine) <input type="checkbox"/> Pain with urination <input type="checkbox"/> Urgency <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Urinary retention <input type="checkbox"/> Abnormal periods
Integument	<input type="checkbox"/> Changes to existing skin lesions or moles <input type="checkbox"/> Rash
Neurological	<input type="checkbox"/> Dizzy/lightheaded <input type="checkbox"/> Headache
Psychiatric	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty Sleeping
Heme-Lymphatics	<input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Unexplained lumps
Others not mentioned above	