



Date: _____

Name: _____ If different, preferred name: _____ Age _____

MEDICATIONS:

Name	Strength/Dose	How often do you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies and reaction: _____

MEDICAL HISTORY:

No Medical Problems

- | | | | |
|--|---|--|--|
| <input type="radio"/> Allergies | <input type="radio"/> Blood clots (legs, lungs) | <input type="radio"/> Eating Disorder | <input type="radio"/> Hypertension |
| <input type="radio"/> Anemia | <input type="radio"/> Bowel Disease | <input type="radio"/> GERD/Acid Reflux | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Anxiety | <input type="radio"/> Cancer | <input type="radio"/> Headaches/Migraines | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Arthritis | <input type="radio"/> COPD | <input type="radio"/> Heart Disease/Murmur | <input type="radio"/> Stroke |
| <input type="radio"/> Asthma | <input type="radio"/> Depression | <input type="radio"/> Hepatitis | <input type="radio"/> Substance dependence |
| <input type="radio"/> Blood transfusion (past) | <input type="radio"/> Diabetes | <input type="radio"/> High Cholesterol | <input type="radio"/> Thyroid disease |
| <input type="radio"/> Other _____ | | | |

GYNECOLOGICAL HISTORY:

First day of your last menstrual period (LMP): _____ How old were you when your period started? _____

Are your periods: Light Moderate Heavy Are periods regular in their timing? Yes No

How many days between your periods? _____ How many days of menstrual flow? _____

Do you have remarkable pain with your periods? Yes No Do you have bleeding in-between periods? Yes No

If applicable, age of menopause/year of last period? _____ Taken hormone meds taken since menopause? Yes No

Do you have any urinary or fecal incontinence? Yes No

Do you have any concerns or questions about your sexual health? Yes No

Are you sexually active now? Yes No

Sexual orientation: Straight Gay Lesbian Bisexual

Current relationship status, circle all that apply: Single Married In a civil union Domestic partnership Multiple partners
Partnered, not cohabitating Divorced Widowed In a committed relationship Other: _____

Name of partner(s): _____

Current form of birth control: _____ Are you happy with it? Yes No

Past methods of birth control (select all that apply): Rhythm/Natural Family Planning Condoms Withdrawal Pill Patch
Nuvaring Depo-Provera Injections Arm Implant Hormone IUD Copper IUD Essure Sterilization Tubal Ligation
Vasectomy Hysterectomy

Date of last Pap test: _____ Was it normal? Yes No Ever had an abnormal Pap or Colposcopy? Yes No

Have you had any treatments to your cervix? No Cryosurgery Laser Surgery LEEP Conization Other _____

Have you ever had a sexually transmitted disease? No Chlamydia Gonorrhea Herpes Other _____

Have you had the HPV vaccine (Gardasil) series? Yes No

FAMILY HISTORY: Check middle column if there is a family history of:

Illness	X	Family Member (example: Sister or Maternal Grandfather)
Diabetes		
High Blood Pressure		
Coronary Artery Disease/Heart attack		
High Cholesterol		
Breast Cancer		
Ovarian Cancer		
Lung Cancer		
Colon Cancer		
Pancreatic cancer		
Melanoma		
Substance dependence		
Depression/Anxiety		
Asthma		
Other		

SOCIAL HISTORY

Occupation: _____

Who do you live with at home? _____

Do you have history of substance dependence? Yes No

How many alcoholic drinks do you have per week: _____

In the last year, have you felt guilty about your drinking, had more than 4 drinks in a day, or lost memory due to drinking? Yes No

Do you use recreational drugs (Marijuana, IV drugs, prescription drugs not prescribed to you)? Yes No

If yes to the above, what do you use and how often? _____

Do you currently smoke? Yes No

Are you ready to discuss quitting today? Yes No

Have you EVER been a smoker? Yes No

If yes: What age did you start smoking?: _____ #/day: _____ When did you quit? _____

PAST OPERATIONS/HOSPITALIZATIONS: No Surgical History

Appendectomy Heart Surgery Colon Surgery Fracture/Trauma Plastic Surgery Brain/Spine

Breast Surgery Hysterectomy Hernia Repair Tubal ligation Joint Replacement C-section

Cholecystectomy (gallbladder) Other GYN surgery: _____

Other surgery: _____

HEALTH CARE SCREENING QUESTIONS

Have you had a mammogram? Yes No Date of last mammo: _____

Have you ever had an abnormal mammogram, breast ultrasound or breast biopsy? Yes No

Have you had a colonoscopy? Yes No Date of last colonoscopy: _____

Have you had a bone density test, for example DEXA scan? Yes No

Do you adhere to any particular diet? Yes No

Do you exercise regularly? Yes No

If you exercise regularly, what type and how often do you exercise? _____

Has anyone close to you ever threatened to hurt you? Yes No

Has anyone ever hit, kicked, choked or hurt you physically? Yes No

Has anyone ever forced you into a sexual experience? Yes No

Have you ever traded sexual acts for money, rent, food, services? Yes No

Are you or have ever been afraid of your current partner? Yes No

Do you wear a seatbelt? Yes No

Do you wear sunscreen? Yes No

Do you have any guns in your home? Yes No

Are you planning a trip or have you been to a Zika endemic area in the last year? Yes No

Country you traveled to: _____ Travel Date: _____

Are you currently involved in any legal proceedings that may impact our care for you? Yes No

PREGNANCY HISTORY: Please list all pregnancies in the table below, for pregnancies that you carried past 20 weeks *please list any complications* during the pregnancy, labor, delivery or post-partum period including preterm hospitalizations, depression/anxiety, gestational diabetes, high blood pressure/pre-eclampsia, weight gain greater than 35 pounds, stillbirth, 3rd or 4th degree delivery laceration, episiotomy, breech delivery, post-partum bleeding, uterine infection/chorioamnionitis, lactation concerns.

Year of pregnancy	Result of pregnancy	Weeks at end of pregnancy	Mode of Delivery	If delivered, sex of baby and name	Infant weight	Name of partner in pregnancy	Complications
	<input type="checkbox"/> Delivery <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage <input type="checkbox"/> Ectopic		<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum				

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS IN THE LAST 2 WEEKS?

- | | |
|--|--------------------------------------|
| Yes No <u>Unintentional</u> weight loss/gain | Yes No Nausea/vomiting |
| Yes No Fever/Chills | Yes No Abdominal pain |
| Yes No Vision Changes | Yes No Frequent or painful urination |
| Yes No Headaches | Yes No Loss of urine |
| Yes No Chest pain/shortness of breath <u>with exertion</u> | Yes No Blood in the urine |
| Yes No Skipped beat or heart palpitations | Yes No New skin rashes |
| Yes No Breast lump or mass | Yes No Mole changes |
| Yes No Cough | Yes No Extremity swelling |
| Yes No Wheezing | Yes No Joint Pain |
| Yes No Nipple discharge | Yes No Anxiety or Depression |
| Yes No Constipation | Yes No Heat/cold intolerance |
| Yes No Diarrhea | Yes No Numbness/Tingling |
| Yes No Blood in stools | Yes No Weakness |

Physician Signature _____ Date reviewed: _____

