

NAME: _____

BIRTHDATE: ____ / ____ / ____

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

DRUG NAME	DOSAGE	PHYSICIAN	DRUG NAME	DOSAGE	PHYSICIAN
ALLERGIES TO MEDICATIONS / SUBSTANCES (LATEX GLOVES, ETC.?)			List:		

CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:

MAJOR ILLNESSES	YES	NO	WHAT BLOOD RELATIVE?
Anemia			
Arthritis / Joint pain			
Asthma			
Bowel Trouble / Ulcers			
Breast Cancer			
Cancer			
Chronic Lung Disease			
Depression / Anxiety / Mood Disorders			
Diabetes			
Glaucoma			
Heart Trouble / Murmur			
Hepatitis / Jaundice			
High Blood Pressure			
High Cholesterol			
Kidney Infections / Stones			
Stroke			
Thyroid Disease			
Tuberculosis - TB			
OTHER:			

YOUR GYN HISTORY

Do you use birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Condoms	<input type="checkbox"/> Nuvaring
<input type="checkbox"/> Depo Provera	<input type="checkbox"/> Birth Control Patch
<input type="checkbox"/> Diaphragm	<input type="checkbox"/> None
<input type="checkbox"/> IUD- Kind	<input type="checkbox"/> Natural Family Plan/Rhythm
- Date Inserted:	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Birth Control Pill	<input type="checkbox"/> Vasectomy
- Name:	<input type="checkbox"/> Withdrawal
<input type="checkbox"/> Contraceptive Foam/Jelly	<input type="checkbox"/> Other:
What age did you have your first period: _____	
How many days are there from start of period to start of next period: _____ days	
How long does your period last? _____ days	Flow: <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy
Number of Tampons per day: _____	Number of Pads per day: _____
Date of Last Period: _____	
Do you have clots? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have breakthrough bleeding? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have cramps? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have pain? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you gone thru Menopause: <input type="checkbox"/> Yes <input type="checkbox"/> No	
At what age: _____	
Are you on Hormone Replacement Therapy (hormones)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

NAME: _____ BIRTHDATE: ____ / ____ / ____

YOUR OB HISTORY

	NUMBER		NUMBER
Total # of pregnancies		Full term births	
Premature		Abortions Induced	
Miscarriages		Living children	

On the chart below, please fill in answers for each pregnancy including abortions or miscarriages.
 If you have had a tubal ligation, previous hysterectomy, or if you are postmenopausal you may skip to the next section.

No.	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight/Sex	Del Type Vag/CSection	Anes	Early Labor?	Wt Gain	Comments / Complications	Location
1				M						
				F						
2				M						
				F						
3				M						
				F						
4				M						
				F						
5				M						
				F						
6				M						
				F						

SOCIAL HISTORY

PLEASE LIST HABITS	
Do you use Seat Belt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you do a Self Breast Exam	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you Drink Milk	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glasses per day:	
Do you Eat cheese or other dairy products	<input type="checkbox"/> Yes <input type="checkbox"/> No
Servings per day:	
Do you Take Calcium	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name and Dosage:	
Do you Exercise:	
<input type="checkbox"/> None <input type="checkbox"/> Less than 3 times per week <input type="checkbox"/> More than 3 times per week	
Are you Sexually Active	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have sex with?	<input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both
First Intercourse at Age: _____	
Frequency: _____ Week	
New sexual partner	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lifetime sexual partners	<input type="checkbox"/> Less than 5 <input type="checkbox"/> More than 5
Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Packs per day:	Number of Years:
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drinks per day:	Drink per week:
Drug User	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kind:	Frequency:
History of abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Sexual	
List all "Natural" or Herbal remedies, over the counter drugs, vitamins or minerals you are taking.	List:

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**REVIEW OF SYSTEMS:
PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLIES TO YOU NOW.**

CONSTITUTIONAL	NOTES	GENITOURNARY (CONT)	NOTES
Weight Loss <input type="checkbox"/>		Decreased sex drive <input type="checkbox"/>	
Weight Gain <input type="checkbox"/>		Painful intercourse <input type="checkbox"/>	
Fever <input type="checkbox"/>		Possible Pregnancy <input type="checkbox"/>	
Fatigue <input type="checkbox"/>		Genital Sores <input type="checkbox"/>	
Night Sweats <input type="checkbox"/>			
Hot Flashes <input type="checkbox"/>		SKIN	
EYES		Rashes <input type="checkbox"/>	
Double vision <input type="checkbox"/>		Itching <input type="checkbox"/>	
Vision changes <input type="checkbox"/>		Skin Dryness <input type="checkbox"/>	
HENT		Skin Lesions <input type="checkbox"/>	
Headaches <input type="checkbox"/>		Changes to Lesions or Moles <input type="checkbox"/>	
Dizziness <input type="checkbox"/>		Acne <input type="checkbox"/>	
Sore Throat <input type="checkbox"/>			
Sinus Pain <input type="checkbox"/>		NEUROLOGICAL	
Nose Bleeding <input type="checkbox"/>		Muscular Weakness <input type="checkbox"/>	
Thyroid Mass <input type="checkbox"/>		Numbness or Tingling <input type="checkbox"/>	
Neck Pain <input type="checkbox"/>		Difficulty Concentrating <input type="checkbox"/>	
BREAST		Memory Difficulties <input type="checkbox"/>	
Lumps <input type="checkbox"/>		Speech Difficulties <input type="checkbox"/>	
Tenderness <input type="checkbox"/>		Seizures <input type="checkbox"/>	
Swelling <input type="checkbox"/>		Loss of Balance <input type="checkbox"/>	
Discharge <input type="checkbox"/>			
Pain in Breast <input type="checkbox"/>		MUSCULOSKELETAL	
Abn Changes in Breast <input type="checkbox"/>		Joint Pain or Swelling <input type="checkbox"/>	
CARDIOVASCULAR		Muscle Pain <input type="checkbox"/>	
Chest Pain <input type="checkbox"/>		Back Pain <input type="checkbox"/>	
Irregular Heart Beats <input type="checkbox"/>			
Rapid Heart Rate <input type="checkbox"/>		ENDOCRINE	
Fainting <input type="checkbox"/>		Loss of Hair <input type="checkbox"/>	
Swelling of legs <input type="checkbox"/>		Difficulty Tolerating Cold <input type="checkbox"/>	
Varicose veins <input type="checkbox"/>		Difficulty Tolerating Heat <input type="checkbox"/>	
RESPIRATORY			
Wheezing <input type="checkbox"/>		PSYCHIATRIC	
Cough <input type="checkbox"/>		Anxiety <input type="checkbox"/>	
Shortness of breath <input type="checkbox"/>		Depression <input type="checkbox"/>	
Spitting up blood <input type="checkbox"/>		Impulsive Behavior <input type="checkbox"/>	
GASTROINTESTINAL		Suicidal Thoughts <input type="checkbox"/>	
Nausea <input type="checkbox"/>		Excessive Anger <input type="checkbox"/>	
Vomiting <input type="checkbox"/>		Mood Swings <input type="checkbox"/>	
Diarrhea <input type="checkbox"/>		Emotional Abuse <input type="checkbox"/>	
Constipation <input type="checkbox"/>		Physical Abuse <input type="checkbox"/>	
Abdominal Pain <input type="checkbox"/>		Sexual Abuse <input type="checkbox"/>	
Bloody / Black Stool <input type="checkbox"/>		HEMATOLOGIC/ LYMPHATIC	
Hemorrhoids <input type="checkbox"/>		Bruises, frequent or easily <input type="checkbox"/>	
Jaundice <input type="checkbox"/>		Cuts do not stop bleeding <input type="checkbox"/>	
GENITOURNARY		Enlarged lymph nodes <input type="checkbox"/>	
Urgency of urination <input type="checkbox"/>		ALLERGIC/IMMUNOLOGIC	
Frequency of urination <input type="checkbox"/>		Frequent illness <input type="checkbox"/>	
Pain with urination <input type="checkbox"/>		Seasonal Allergies <input type="checkbox"/>	
Nighttime urination <input type="checkbox"/>		OTHER	
Losing urine <input type="checkbox"/>		1. <input type="checkbox"/>	
Blood in urine <input type="checkbox"/>		2. <input type="checkbox"/>	
		3. <input type="checkbox"/>	