

Name _____ Age _____ Marital Status _____ Date _____

Employer/Occupation _____ Smoking _____

Reason for Visit

Pregnancy History

Total Pregnancies _____ Full Term _____ Pre-term _____ Miscarriage/Abortion _____

Date	Length of Pregnancy	Type of Delivery	Sex	Weight	Living
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Menstrual History

At what age did you start having menstrual periods? _____

Number of days between first day of one and first day of next period? _____

Length of period? _____ Regular or Irregular _____

Would you call your periods () light () medium () heavy () clots

When was the first day of your last menstrual period? _____ Do you have cramps? _____

Was it a normal period? _____ If not, when was the last normal one? _____

Have you ever had a sexually transmitted disease? _____

Comments

Date of last mammogram _____ Have you had an abnormal mammogram? _____

If yes, please give date and explain _____

Date of last pap smear? _____ Have you ever had an abnormal pap smear? _____

If yes, please give dates, type (CIN I, HPV, etc.) and treatments

