**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_ Marital Status \_\_\_\_\_ Date \_\_\_\_\_\_\_**

# Reason for Visit

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **Allergies to Medications/Latex/Iodine:**

If yes, please name medicine and describe type of reaction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications and Supplements**

Please give name and dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Pregnancy History

Total Pregnancies\_\_\_ Full Term\_\_\_ Pre-term\_\_\_ Miscarriage\_\_\_ Abortion\_\_\_ Ectopic\_\_

Date Length of Pregnancy Type of Delivery Sex Weight Living Complications

\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

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## **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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods/cramps? \_\_ Y \_\_ N

**Contraception**

What is your current form of birth control?

Abstinence Birth Control pill Hysterectomy IUD Menopause Tubal ligation Vasectomy Nuvaring Patch Depoprovera Rhythm Condoms Nexplanon Nothing

How long have you been using your current form of birth control? (please check one)

\_\_ 2 yrs or less \_\_ 3-5 yrs \_\_ 6-10 yrs \_\_ over 10 yrs

When are you planning to have another child? (please check one)

 \_\_ within 1-2 yrs \_\_ within 5-10 yrs \_\_ my family is complete

If menopausal, at what age did your periods stop? \_\_\_\_\_\_\_

Date of last pap smear? \_\_\_\_\_\_\_ Normal/Abnormal? Have you had an abnormal pap smear? \_\_\_\_\_

If yes, please give dates, type (ASCUS, HPV, CIN I, etc.) and treatments (Colposcopy, Cryo, Cone Biopsy, LEEP) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last mammogram? \_\_\_\_\_ Normal/Abnormal? Have you had an abnormal mammogram? \_\_\_\_

If yes, please give dates and explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Bone densitometry? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal / Osteopenia / Osteoporosis

# Past Medical History

Please check if you currently have or have had a history of any of the following:

YES NO

( ) ( ) Reflux/Heartburn

( ) ( ) Spastic Colon/Irritable Bowel

( ) ( ) Hepatitis

( ) ( ) Ulcers

( ) ( ) Hypertension

( ) ( ) Heart Disease

( ) ( ) Angina

( ) ( ) Heart Murmur

( ) ( ) Hypercholesterolemia

( ) ( ) Blood Clotting Problems/DVT

( ) ( ) Asthma

( ) ( ) Sleep apnea

( ) ( ) Tuberculosis

( ) ( ) Pneumonia

( ) ( ) Emphysema

( ) ( ) Kidney/Bladder Infections

( ) ( ) Kidney Stones

YES NO

( ) ( ) Fibromyalgia

( ) ( ) Arthritis-Rheumatoid/Osteo

( ) ( ) Diabetes

( ) ( ) Thyroid Problems

( ) ( ) Osteoporosis

( ) ( ) Nervous Disorder/Depression

( ) ( ) Rheumatic Fever

( ) ( ) Migraines

( ) ( ) Dementia

( ) ( ) Stroke/TIA

( ) ( ) Epilepsy

( ) ( ) Anemia

( ) ( ) Sickle Cell Disease/Trait

( ) ( ) Allergies

( ) ( ) Eczema

( ) ( ) Psoriasis

( ) ( ) Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) ( ) Hospitalizations - If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is blood transfusion acceptable in an emergency?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an Advance Directive?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Past Surgical History

Dates: Procedure:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Immunizations (please list dates)**

Tetanus: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HPV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Flu: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

YES NO YES NO

( ) ( ) Breast Cancer ( ) ( ) Diabetes

( ) ( ) Ovarian Cancer ( ) ( ) Thyroid Disorder

( ) ( ) Uterine Cancer ( ) ( ) Osteoporosis

( ) ( ) Colon Cancer ( ) ( ) Epilepsy/Seizures

( ) ( ) Heart Disease ( ) ( ) Stroke

( ) ( ) Hypercholesterolemia ( ) ( ) Depression/Bipolar/Schizophrenia

( ) ( ) Hypertension ( ) ( ) Birth Defects

( ) ( ) DVT/Pulmonary Embolus ( ) ( ) Other

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Employer/Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exercise Type/Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education Level\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoking \_\_\_cigs/day Vaping\_\_\_ Alcohol \_\_drinks/wk Caffeine \_\_\_servings/day Illicit Drugs\_\_\_\_\_ Have you ever had a sexually transmitted disease? \_\_\_\_\_\_\_\_ Type/dates\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you feel safe in your current relationship?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Symptoms:  (Circle current symptoms)**

**GENERAL** - Fatigue Fever Weight gain Weight loss

**CARDIOVASCULAR** – Palpitations Chest pain

**PULMONARY** - Cough Shortness of breath

**GASTROINTESTINAL** - Bloating Constipation Diarrhea Hemorrhoids Bloody stools Nausea

**URINARY** - Pain with urination Blood in urine Frequency UTI’s Incontinence

**GENITAL** - Irregular periods Painful intercourse History of sexual abuse Vaginal discharge Vaginal itching

**MUSCULOSKELETAL** - Back pain Joint pain

**BREAST** – Perform self breast exams-Regularly/Irregularly/Never Masses Tenderness Nipple discharge

**SKIN** - Rash Warts

**NEUROLOGIC** - Dizziness Headaches

**BLOOD/LYMPHATIC** - Easy bruising Bleeding easily History of blood transfusion Enlarged lymph nodes

**ENDOCRINE** – Hair loss Temperature intolerance Excessive hair growth

**ALLERGIES** – Seasonal allergies

**PSYCHIATRIC** - Anxiety Depression PMS Insomnia