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Name \_\_\_\_\_ Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

<b>MENSTRUAL HISTORY</b>	YES	NO
Regular periods	_____	_____
Pain with period	_____	_____
Bleeding between periods	_____	_____
Cramps	_____	_____
Mood swings/irritability	_____	_____
Weight gain	_____	_____
Breast tenderness	_____	_____
Age at first period	_____	_____
Period is: (circle) Light / Moderate / Heavy / Clots	_____	_____

<b>GYNECOLOGICAL HISTORY</b>	YES	NO
History of Abnormal Pap	_____	_____
Resulting procedures performed?	_____	_____

<b>UTERINE ABNORMALITIES</b>	YES	NO
Infection of the tubes/uterus	_____	_____
Uterine fibroids	_____	_____
Ovarian cysts	_____	_____
Endometriosis	_____	_____
Cervicitis	_____	_____

<b>SEXUALLY TRANSMITTED DISEASES</b>	YES	NO
Gonorrhea	_____	_____
Syphilis	_____	_____
Chlamydia	_____	_____
Genital Herpes	_____	_____
Genital Warts	_____	_____
Trichomonas	_____	_____

<b>CONTRACEPTIVE HISTORY</b>	YES	NO
HAVE YOU USED:		
Pill	_____	_____
IUD	_____	_____
Diaphragm	_____	_____
Condom	_____	_____
Nuva-Ring	_____	_____
Tubal ligation	_____	_____
Depo Provera	_____	_____
Problems/Side Effects	_____	_____

<b>OBSTETRICAL HISTORY</b>	NUMBER OF:
Total Pregnancies	_____
Full Term Pregnancies	_____
Preterm Pregnancies	_____
Miscarriages	_____
Abortions	_____
Living Children	_____

<b>PERSONAL MEDICAL HISTORY</b>	YES	NO	WHEN
Diabetes	_____	_____	_____
Thyroid problems	_____	_____	_____
Cancer	_____	_____	_____
Heart Disease	_____	_____	_____
Breast disease/mass	_____	_____	_____
Stroke	_____	_____	_____
Anemia	_____	_____	_____
Bladder or Kidney disease	_____	_____	_____
Depression	_____	_____	_____
Liver disease/Hepatitis	_____	_____	_____
Migraines	_____	_____	_____
Blood vessel clots	_____	_____	_____
Lung disease	_____	_____	_____

**HOSPITALIZATIONS & SURGERIES**  
 please include dates  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICATIONS**  
 Allergies to medications? \_\_\_\_\_  
 Are you on any medications? \_\_\_\_\_  
 \_\_\_\_\_

<b>FAMILY MEDICAL HISTORY</b>	YES	NO	RELATIVE
HAS ANYONE IN YOUR FAMILY HAD:			
High Blood Pressure	_____	_____	_____
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
Stroke	_____	_____	_____
Alcoholism	_____	_____	_____
Osteoporosis	_____	_____	_____
Inherited genetic disease	_____	_____	_____
Cancer	_____	_____	_____
Other	_____	_____	_____

<b>SEXUAL HISTORY</b>	YES	NO	DETAILS
Age at first intercourse	_____	_____	_____
Are you currently sexually active	_____	_____	_____
Any pain during intercourse	_____	_____	_____
Bleeding with intercourse	_____	_____	_____
Do you practice anal sex	_____	_____	_____
Frequency of sex per week	_____	_____	_____
Have you had a new partner in the last two months?	_____	_____	_____

<b>HABITS</b>	YES	NO	FREQUENCY
Do you smoke cigarettes?	_____	_____	_____
Consume alcoholic beverages?	_____	_____	_____
Do you use illegal drugs?	_____	_____	_____