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_______________ Last Name | _______________ First Name | _____ Initial | _______ Age | ___/___/___ Today's date

____/____/____ Date of birth | ____/_____/____ Last period | _________ Last Pap | ______________ Last Mammogram

REASON FOR TODAY'S APPOINTMENT:

MEDICAL HISTORY :(Check the box if you have had problems with the following)

- o Skin
- o Eyes/vision
- o Ears/hearing
- o Mouth/teeth
- o Anemia
- o Cancer
  What kind?
- o Diabetes
- o Thyroid disease
- o migraines
- o Seizures/epilepsy
- o Psychiatric problems
- o depression
- o High cholesterol
- o Heart disease
- o High blood pressure
- o Asthma
- o Bleeding problems
- o Blood transfusions
- o Hepatitis
- o Lung disease
- o Breast lump
- o Breast discharge
- o Breast surgery
- o Gall bladder disease
- o Stomach Ulcer
- o Black or bloody stools
- o Kidney
- o Bladder infections
- o Gonorrhea
- o Syphilis
- o Chlamydia
- o genital wart
- o Herpes
- o HIV/AIDS
- o Broken bones
- o Back pain
- o Joint problems
- o arthritis
- o Vaginal infection
- o Pelvic tumor
- o Pelvic infection
- o Abnormal pap
- o Endometriosis
- o Fibroids
- o Ovarian tumors
- o Breast biopsy

FAMILY HISTORY: Are you Adopted? __No __Yes
(Check the box if your parents, siblings or children have had any of the following, and list who)

- o Alcoholism
- o Arthritis
- o Asthma
- o Bleeding Problems
- o Diabetes
- o High blood pressure
- o Heart attack
- o Stroke
- o Osteoporosis
- o Mental disease
- o Depression
- o Breast Cancer
- o Ovarian Cancer
- o Colon Cancer
- o Other Cancers
- o Birth defects

RACE/ETHNICITY:

- o White
- o Black
- o Chinese
- o Native American
- o Asian-East Indian
- o Filipino
- o Japanese
- o Middle Eastern
- o Hispanic
- o Other Southeast Asian
- o Other
- o Unknown

ALLERGIES: (food and medication):

CURRENT MEDICATIONS/HERBAL SUPPLEMENTS:

HOSPITALIZATIONS/SURGERIES: (list all except for pregnancy)

Date	Hospitalizations/surgeries	Date	Hospitalizations/surgeries

PREGNANCY HISTORY:

Year	Delivery(vaginal/C/S, Miscarriage, termination, ectopic)	Gender	Weight	Hospital	Complications

GYNECOLOGICAL HISTORY:

Menses:

Age when menses began _________________

Periods come every ___days and last for ___days

Blood flow during period is: ___light ___moderate ___heavy

Are your periods painful? ___Y ___N

Birth control:

Are you having intercourse? ___Y ___N

What birth control method(s) are you currently using? __________________

Do you want to change your method of birth control? ___Y ___N

Please check any symptom(s) you are <u>currently</u> having:

- irregular periods
- pain with your menses
- pain with ovulation
- dissatisfied with sexual relations
- pain with intercourse
- bleeding between periods
- bleeding after intercourse
- bleeding from your rectum
- vaginal discharge
- vaginal itching
- vaginal burning
- breast discharge
- lump(s) in breast
- unusual hair growth
- hot flashes
- trouble sleeping
- vaginal dryness
- night sweats
- feel anxious
- feel sad/depressed
- strong urge to urinate
- the sight or sound or feel of running water cause you to leak urine
- unaware that you are leaking urine
- leak urine when you cough, laugh or sneeze
- wear a pad because of urine leakage
- feeling of pressure or bearing down
- bulging from your vagina

Do you currently:

- Perform self breast exams
- Exercise regularly
- Drink alcohol: how much?
- Smoke cigarettes: ____packs/day
- Use recreational drugs