

DATE: _____ NAME: _____ DOB: _____ AGE: _____

WHY ARE YOU HERE TODAY?

DRUG, MEDICATION OR FOOD ALLERGIES:

PRIMARY CARE PROVIDER

OBSTETRICAL/GYNECOLOGICAL HISTORY
Menstrual history (skip if you are post menopausal)

Age when you got first period: _____ First day of last period: _____ Any problems with period?

 no yes:

of days you bleed: _____ # of days between period: _____ Amount of bleeding?

 heavy medium light

SEXUAL HISTORY

 I have sex with: male partner(s) female partner(s) If you have/had intercourse,

 bi-sexual partners male and female not active

age at first time: _____

 I have had, or my partner has had, a new partner since last visit: no yes not active

 Do you have any bleeding with sexual activity: no yes Date of last pap: _____

PREGNANCY HISTORY

of full-term pregnancies: _____ # of premature pregnancies: _____ # of vaginal births: _____

of miscarriages: _____ # of abortions: _____ # of c-sections: _____

of living children: _____ # of children placed for adoption: _____ # of children adopted: _____

CONTRACEPTIVE HISTORY

 If you use a birth control method, what is it: _____ ? or problems with it: no yes

Other methods used: _____ Interested in changing methods?

MENOPAUSE AND BEYOND (skip if not menopausal)

 Age you stopped having periods: _____ Problems or concerns? no yes

 Taking hormone replacement therapy (HRT): no yes Interested in learning more about HRT?

 no yes

GYNECOLOGY HISTORY - check if you have or have had

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal uterine bleeding | <input type="checkbox"/> Pelvic pain | <input type="checkbox"/> Abnormal pap smear/treatment |
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Ovarian cysts or tumors | <input type="checkbox"/> Premenstrual syndrome | <input type="checkbox"/> Pelvic infection |
| <input type="checkbox"/> Loss of urine or feces | <input type="checkbox"/> Vaginitis (yeast, BV, "trich") | <input type="checkbox"/> Chlamydia/gonorrhea |
| <input type="checkbox"/> Infertility issues | <input type="checkbox"/> Do you douche? | <input type="checkbox"/> Herpes |

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MEDICAL AND FAMILY HISTORY I HAVE NO KNOWLEDGE OF MY FAMILY HISTORY

Check if yes:	Self	Family	Check if yes:	Self	Family	Check if yes:	Self	Family
Breast cancer			High cholesterol			Skin problems		
Ovarian cancer			High blood pressure			Jaundice/hepatitis		
Colon cancer			Blood clots lungs/leg			Tuberculosis		
Uterus cancer			Thyroid problems			HIV/AIDS		
Other cancer:			Lung problems			Anemia		
Diabetes			Breast problems			Birth defects		
Heart disease			Colon problems			Varicose veins		
Rheumatic fever			Reflux/Ulcer			Headache/migraines		
Stroke			Stomach problem			Seizure/epilepsy		
Osteoporosis			Gall bladder problem			Depression/anxiety		
Bone/hip fracture			Kidney/bladder prob			Other mental illness		
Arthritis/joint pain			Urine infections			Other:		

HOSPITALIZATION, SURGERIES, ACCIDENTS OR SERIOUS ILLNESS

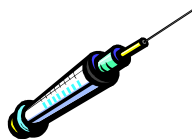
	YEAR:		YEAR:
	YEAR:		YEAR:
	YEAR:		YEAR:
	YEAR:		YEAR:

MEDICATIONS, VITAMINS, HERBS AND SUPPLEMENTS

PREVENTION

VACCINATION RECORD

- I have had tetanus in last 10 years
- I have had measles, mumps, and rubella or vaccinated _____
- I have had chicken pox or vaccinated
- I have had Hepatitis B vaccinations
- If over 65, I have had Pneumovax



HEALTH MAINTANENCE ISSUES

- I eat a well balanced diet
- I exercise at least 3X/wk
- I get 1000-1500 mg of calcium daily
- I use seat belts
- I use protective gear for work and play
- I take Folic acid daily
- I use sun screen and limit exposure to UV light



NICOTINE USE

- I am an ex-smoker
- I am a non-smoker
- I smoke cigarettes, cigars, pipes
- I use smokeless tobacco
- I started at age _____ and smoke _____ packs per day
- I am interested in learning how to quit

ALCOHOL/DRUG USE

- I am a non-drinker
- I drink _____ glasses of alcohol per day
- I have felt like I should cut down
- I feel guilty about my drug and/or alcohol use
- People tell me to cut down or quit
- I need to use alcohol and/or drugs as a pick me up when I first wake up

HIV/HEPATITIS RISK

- Since becoming sexually active, I have had _____ partners
- I use condoms with new partners
 - I have or have had unprotected anal sex
 - I have or am using needles to inject drugs
 - I have or am selling sex for money or drugs
 - I have or have had a partner who is an IV drug user
 - I have or have had a partner who is HIV/AIDS positive

DOMESTIC VIOLENCE - As we are concerned about your safety and because it is so common, we are asking all our patients about the presence of violence and abuse in their home. Are you being

- Hurt
- Insulted or talked down to
- Screamed at or cursed
- Threatened with physical harm
- I have a history of sexual abuse/battering