NAME Dr. ☐ Ms. ☐ Mrs. ☐ Miss ☐ _____ LAST MIDDLE FIRST Single ☐ Married ☐ Divorced ☐ Widow ☐ Date _____

AGE _____ DATE OF BIRTH _____ BIRTH PLACE _____

OCCUPATION _____ ALL PREVIOUS OCCUPATIONS _____

EDUCATION _____ YEARS HIGH SCHOOL _____ YEARS COLLEGE _____ YEARS POST GRADUATE

SOCIAL SECURITY # _____ MEDICARE # _____

Reason for today's visit: (please list all symptoms)

Please do not write in this space

1. _____
2. _____
3. _____
4. _____
5. _____

GYNECOLOGICAL HISTORY

MENSTRUAL PERIODS:

The first day of your most recent period _____
The age your periods started _____
The age your periods stopped _____
Are your periods regular? ☐YES ☐NO ☐N/A
The usual number of days from the start of one period to the start of your next period _____ days
The usual number of days your period lasts _____ days
The flow of your period ☐LIGHT ☐MEDIUM ☐HEAVY
Do you have cramping or pain with your periods? ☐YES ☐NO
Do you have bleeding between periods? ☐YES ☐NO
Do you have bleeding with intercourse? ☐YES ☐NO
Do you have a vaginal discharge today? ☐YES ☐NO
Do you have urinary incontinence? ☐YES ☐NO
Are you currently sexually active? ☐YES ☐NO

What prescription medicines do you **take regularly**

_____
_____
_____
_____
_____

If you are sexually active and can become pregnant, what do you or your partner use for birth control? _____
The month and year of your most recent Pap smear _____
Have you ever had an abnormal Pap smear in the past? ☐YES ☐NO
If yes, how long ago? _____
The year of your most recent mammogram _____

PREGNANCIES:

How many times were you pregnant? _____
How many live births have you had? _____
How many still births have you had? _____
How many miscarriages have you had? _____
How many abortions have you had? _____
How many tuba]/ectopic pregnancies have you had? _____
How many caesarean sections have you had? _____

ALLERGIES: are you allergic to:

betadine _____
novacaine _____
penicillin _____
sulfa _____
aspirin _____
codeine _____
any other drug(s): _____
_____

- FAMILY HISTORY -

	Age	If Living Please List ALL Medical Conditions And Illnesses	Age At Death	If Deceased -- Cause Of Death
Father				
Mother				
Brother				
Brother				
Brother				
Sister				
Sister				
Sister				

Have any relatives ever had Breast Cancer? _____

PLEASE TURN OVER

PERSONAL MEDICAL HISTORY
PLEASE CIRCLE ALL THAT APPLY:

	AGE
high blood pressure	
heart disease	
heart attack	
stroke	
phlebitis	
emphysema	
asthma	
bronchitis	
pneumonia	
tuberculosis	
ulcer	
colitis	
gall bladder disease	
hepatitis	
mononuclosis	
thyroid problems	
diabetes	
urinary infection	
kidney stones	
epilepsy	
nervous or mental disorders	
arthritis	
gonorrhea	
syphillis	
herpes	
chlamydia	
veneral warts	
P. 1. D.	
mumps	
chicken pox	
German measles	
rheumatic fever	
cancer (type)	
blood transfusions	

other _____

_____

_____

_____

_____

SURGICAL HISTORY
PLEASE CIRCLE ALL THAT APPLY:

	AGE
tonsillectomy	
hernia operation	
hemorrhoid operation	
thyroid operation	
gall bladder operation	
varicose vein operation	
D & C	
laparoscopy	
tubal ligation	
removal of tube or ovary	
hysterectomy	
breast biopsy	
colposcopy	
cone biopsy/LEEP	
lumpectomy	
mastectomy	

other: _____

_____

_____

INJURIES: have you had:

	AGE
concussion or head injury	
car accident injury	
ever been knocked unconscious?	

other: _____

_____

_____

Do you drink alcoholic beverages? ☐ YES ☐ NO

_____ number of drinks per week

Do you have any sexual concerns you would like to discuss?

_____

_____

_____

Do you currently smoke? ☐ YES ☐ NO

_____ packs per day currently, _____ number of years

If not smoking now, have you ever smoked? ☐ YES ☐ NO

How long has it been since you last smoked? _____

Name of physicians that are familiar with your medical history: _____

_____

_____

_____

_____

_____