Patient Name:_____ **Date of Birth:**_____ **Age:** _____

For office use only: Weight: **Height:**

What is the purpose for your appointment today?	**Comprehensive/ Annual Exam**	**Contraception**	**Difficulty getting Pregnant**	**Breast Problems**	**Pelvic organ prolapse**	**Premarital Exam**
	Menopausal Symptoms	**Menstrual Problems**	**Pelvic Pain**	**Emotional Problems**	**Urinary Incontinence**	**Other:**

PLEASE FILL OUT COMPLETELY / CIRCLE ALL THAT APPLY

FAMILY HISTORY	**Personal Medical History**	**Personal Surgical History**	**Personal Social HIstory**	**Reproductive History**	**Current Medications**	
Anesthesia Reaction:	Anesthesia	Abdominal Surgery	Race/ Ethnicity:	Total # of Pregnancies:	***Drug***	***Dose***
	Anemia	Appendectomy				
Blood Clots / DVT:	Anxiety / Depression	Bladder Surgery	Religion:	# of Full Term Deliveries:		
	Arthritis / Joint Pain	Breast Augmentation				
Breast Cancer:	Asthma / Lung Disease	Breast Surgery	Marital Status:	# of Preterm Deliveries		
	Bowel Problem / IBS	C-Section				
Diabetes:	Cancer	Ectopic Pregnancy	Occupation:	# of Miscarriages or Abortions:		
	Clotting Disorder	Endometrial Ablation				
Drinking Problems:	Diabetes I or II	Essure	Level of Exercise:	# of Living Children:		
	DVT / Blood Clot / PE	Fibroid Removal				
Heart Disease:	Ectopic Pregnancy	Gallbladder Removal	Level of Education:	# of Ectopic Pregnancies		
	Fibroid Uterus	Hand Surgery				
High Blood Pressure:	Endometriosis	Hernia Repair	***Circle all the apply:***	# of Adopted Children:		
	Epilepsy / Seizures	Hysterectomy	History of STD Specify:			
Ovarian Cancer:	Heart Disease	Hysteroscopy			**Allergies to Medications**	
	Hepatitis / Liver Disease	Knee Surgery		***Circle all that apply***	***Drug***	***Reaction***
Stroke:	High Blood Pressure	Laparoscopy	History of 5 or more Partners	Infertility	Penicillins	
	Kidney Disease / Stone	Ovarian Cyst Surgery		Uterine anomaly	Sulfas	
	Menstrual Problems	1 Ovary removed	Start of sexual activities before 16yrs		Cephalosporins	
	Migraine Headaches	Both Ovaries			Erythromycin	
	Osteoporosis	Shoulder Surgery	**Tobacco Use**		Percocet	
	PCOS	Sling	**Alcohol Use**		Morphine	
	Thyroid Disorder	Tonsillectomy	Illicit Drug Use		Codeine	
	Skin Disorder	Tubal Ligation	Domestic Abuse		Other:	

CURRENT MENSTRUATION: * If you are menopausal, PLEASE skip this section**

Please list the first date of your last menstrual cycle:	Date:_____				
What best describes the regularity of your menstrual cycles?	Regular	Irregular	Infrequent	Infrequent due to an: (circle one) IUD BC Pills Implanon	
How often do your menstrual cycle occur? Every?	24-35 days	less than 23 days	36-60 days	1-3 Per Year	Rarely
How would you best describe your menstrual flow on most days of your cycle?	Normal	Light	Moderate	Heavy	Heavy w/ clots
How many days do you bleed during an average menstrual cycle?	4-7 Days	Less than 2 Days	2-4 Days	7-10 Days	More than 10 days
Do you bleed or spot between cycles?	No	Occasionally	Frequently		
How would you best describe your cramps / pain during your menstrual cycles?	Mild	None	Moderate	Severe	Debilitating
Do you experience any premenstrual syndrome (PMS) Symptoms?	No	Minimal	Moderate	Severe	Debilitating
Do you experience any perimenopausal symptoms?	No	Hot Flashes	Mood Swings	Sleep Disturbances	Bleeding Irregularities

MENOPAUSAL: ***If you are still having menstrual cycles PLEASE skip this section

How many years since your last menstrual cycle?	1 yr	2 yrs	3-5 yrs	6-10 yrs	More than 10 yrs
How did your menopause occur?	Naturally	Secondary to Hysterectomy		Secondary to Hysterectomy removal of ovary / ovaries	
Do you have POSTmenopausal vaginal bleeding?	No	Occasionally	Frequently	Only with Intercourse	
Do you experience any menopausal symptoms? (Circle all that apply)	No	Hot Flashes	Mood Swings	Sleep Disturbances	Vaginal dryness
Are you currently using any hormone therapy?	No	Yes			

SEXUAL HISTORY						
Are you sexually active?	Yes	Never	Previously, Not Now			
What do you use for contraception?	Nothing	BC Pills/ Nuvaring	Condoms	IUD	Tubal Occlusion	Partner's vasectomy
Do you have any of the following problems with intercourse?	No	Pain	Spotting	Dryness	Other:	

PAP SMEAR HISTORY:						
How many years was your last Pap Smear?	less than 1 yr	1-2 yrs	3-4 yrs	5-10 yrs	More than 10 yrs	Never
Have you ever had an abnormal Pap Smear	No	Yes				
If YES..How many years ago was your last Abnormal Pap Smear?	less than 1 yr	1-2 yrs	3-4 yrs	5-10 yrs	More than 10 yrs	
Circle any procedures you have ever had done	None	Colposcopy	Biopsies	Cryo/Freezing	LEEP	Cone

BREAST & OVARIAN CANCER SCREENING:						
How many years ago was your last mammogram?	Never	less than 1 yr	1-2	More than 3 yrs	**Every 1-2 Years after age 40. Every year after age 50**	
Have you ever had an abnormal mammogram?	No	Yes				
Do you have any of the following symptoms? (circle all that apply)	No	Breast Mass/Lump	Breast Pain	Nipple Discharge	Skin Changes	
Do you or a family member have a history of BREAST CANCER?	No	Mother	Sister	Grandma	Aunt	Other:
Do you or a family member have a history of OVARIAN CANCER?	No	Mother	Sister	Grandma	Aunt	Other:

UTERINE & COLON CANCER SCREENING:						
How many years ago was your last Colonoscopy?	Never	1-5	6-10	More than 10 yrs	Every 10 years after age 50	
Have you ever had an abnormal Colonoscopy?	No	Yes				
Do you have the following symptoms?	No	Rectal bleeding or pain	Change in bowel habits	Postmenopausal bleeding	Bleeding between periods	
Do you or a family member have a history of Uterine Cancer?	No	Mother	Sister	Grandma	Aunt	Other:
Do you or a family member have a history of Colon Cancer?	No	Mother / Father	Sister	Grandparent	Aunt / Uncle	Other:

OSTEOPOROSIS SCREENING						
Are you currently doing any of following to prevent bone loss?	No	VitD Magnesium	Estrogen	Prescription Medication	Every 2 years after age 65 or after 60 w/ 2+ risks	
How many years ago was your bone density (dexa) scan?	Never	1-2	3-5	More than 5 yrs		
Do you or a family member have a history of Osteoporosis or Osteopenia?	No	Parent	Sibling	Grandparent	Other:	
Circle any of the following risks factors for Osteoporosis that apply to you.	None	Menopausal	Small body Frame	European or Asian ancestry	Ovaries removed before menopause	
		More than one fracture	Tobacco use	Alcohol use	Hyperthyroid	Long Term corticosteroids

PERIODIC SCREENINGS:					
How many years has it been since you last had your Cholesterol checked?	Never	Less than 3 yrs	3-5	More than 5 yrs	Every 5 years after age 45
How many years has it been since you last had your Thyroid checked?	Never	Less than 3 yrs	3-5	More than 5 yrs	Every 5 years after age 50
How many years has it been since you last had your Fasting Glucose checked?	Never	Less than 3 yrs	3-5	More than 5 yrs	Every 3 years after age 45
Would you like to have testing for Sexually Transmitted Infections?	No	Yes			
			PAP YES / NO	***BLOOD WORK***	***FASTING YES / NO***