Please complete the following information as accurately as possible. Your answers on this form will help your provider understand your medical concerns and conditions better. If you cannot remember specific details, please give best estimates.

G____ P____ A____ LC____
OFFICE USE ONLY

Name _____ Age_____ DOB _____ Date _____
Date of Last Period _____
Current Method of Birth control _____
Are you interested in being tested for sexually transmitted infections: YES ___ NO ___
Are you interested in receiving the HPV Vaccine: YES___ NO___

1. **Current Medications:** Prescription and non-prescription medicine, vitamins, home remedies, birth control pills, herbs

	Dosage (mg)	Frequency	Date Started	Prescribing physician

2. **What is the reason for your visit?**

   _____

   _____

3. **Present health concerns; additional problems:**

   _____

   _____

4. **Menstrual History:**
   Age at first period: _____ Are your periods: ___light ___moderate ___heavy
   Length of each period: _____ Do you have cramps? ___No ___Mild ___Moderate ___Severe
   Do you have concerns about your period? ___ Yes ___ No
   Do you have symptoms of menopause? ___ Yes ___ No
   Frequency of Periods: _____
   1st day (date) of most recent period: _____

5. Past Medical History (check all boxes that apply)

How would you rate your general health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Mammogram Date: Results:

Ever Abnormal? ☐ Yes ☐ No Details:

Papsmear Date: Results:

Ever Abnormal? ☐ Yes ☐ No Details:

Please indicate whether you have had any of the following medical problems and when (dates):

☐ Alcoholism _____
☐ Bleeding/Clotting Problems_____
☐ Blood Transfusion _____
☐ Cancer (Malignancy)_____
Specific Type _____
☐ Depression/Suicide Attempt_____
☐ Diabetes _____
☐ Heart Attack _____
☐ Heart Disease _____
☐ High Blood Pressure_____
☐ High Cholesterol_____
☐ Thyroid Problems_____
Specific Type _____

List Others:

6. Please list any surgeries, illnesses or new medical problems since your last visit

Date	Illness or Operation	Complications

7. Allergies (Drug, Food, Environment) **Reactions**

8. Family History

Please indicate below significant medical problems of family members. Indicate which family members by checking the appropriate column.

	Mother	Father	Brother	Sister	Grandmother (Maternal)	Grandmother (Paternal)	Grandfather (Maternal)	Grandfather (Paternal)	Aunt	Uncle
Arthritis										
Blood Clots										
Breast Cancer										
Cervical Cancer										
Diabetes										
Elevated Cholesterol										
Heart Disease										
High Blood Pressure										
Ovarian Cancer										
Stroke										
Other Cancer (not mentioned)										
Other Disease (not mentioned)										
Osteoporosis										
Uterine Cancer										

9. Social History

Occupation	What is your current occupation?		
Marital Status	☐ Divorced ☐ Domestic Partner ☐ Married ☐ Remarried ☐ Single ☐ Widowed		
Sexual Activity	Are you sexually active? ☐ Yes ☐ No ☐ Not currently Current Sex Partner(s) is/are: ☐ Male ☐ Female Have you had more than 4 sexual partners in your life time? ☐ Yes ☐ No Have you ever had any sexually transmitted diseases (STDs)? ☐ Yes ☐ No Partner's Name: _____ Partner's Occupation:_____		
Alcohol Use	☐ Yes ☐ No	Drinks per week: _____	Is alcohol use a concern for your or others? ☐ Yes ☐No
Tobacco Use	Cigarettes? ☐ Never ☐ Quit, Date: _____ ☐ Current Smoker, Packs per day _____ Number of years: _____ Other tobacco: _____ Are you interested in quitting smoking? ☐ Yes ☐ No		
Safety	Do you use seat belts consistently? ☐ Yes ☐ No Is violence at home a concern for you? ☐Yes ☐No		
Drug Use	Do you use recreational drugs? ☐ Yes ☐ No		

10. OB History

Summary of Previous			Full Term		Premature		Abortions/Miscarriages			Now Alive	
	DOB	Hospital	Weeks Gestation	# Hrs in labor	Vaginal or C-Section	Sex	Birth Weight	Mother's Total Weight Gain	Rhogam Injection	Mother	Infant
1											
2											
3											
4											
5											
6											

11. Review of Body Systems: (check all that are applicable and explain if needed)

Constitutional	☐ Chills ☐ Excessive urination ☐ Fever ☐ Weight gain ☐ Excessive thirst ☐ Fatigue ☐ Night sweats ☐ Weight loss
Eyes	☐ Recent changes in vision
H.E.N.T. (Head, ears Nose & Throat)	☐ Hay fever or allergies ☐ Problems with teeth and gums ☐ Sinus pain/congestion
Cardiovascular	☐ Chest pain ☐ Palpitations
Respiratory	☐ Cough ☐ Shortness of breath ☐ Wheezing
Gastrointestinal	☐ Abdominal pain ☐ Blood in stools ☐ Diarrhea ☐ Vomiting ☐ Bloating ☐ Constipation ☐ Nausea
Genitourinary/Gynecological	☐ Frequency ☐ Incontinence ☐ Sexual Dysfunction ☐ Hematuria (blood in urine) ☐ Pain with urination ☐ Urgency ☐ Vaginal Discharge ☐ Urinary retention ☐ Abnormal periods
Integument	☐ Changes to existing skin lesions or moles ☐ Rash
Neurological	☐ Dizzy/lightheaded ☐ Headache
Psychiatric	☐ Anxiety ☐ Depression ☐ Difficulty Sleeping
Heme-Lymphatics	☐ Bleeding Disorder ☐ Unexplained lumps
Others not mentioned above	