

NAME _____

DATE _____
Single () Living Together (optional) ()

BIRTHDATE _____

Married () Years Married _____

HEIGHT _____ WEIGHT _____

PARTNER'S NAME _____ AGE _____

OCCUPATION _____

Divorced () Separated () Widowed ()

What do you consider your racial designation? Caucasian () Black () Hispanic () Japanese/Chinese () Korean ()
South East Asian () Filipino () Native American () Other () _____

Religious Preference (optional) _____

What Physician referred you to our office? _____

PRIMARY CARE PROVIDER _____

MENSTRUAL HISTORY

- _____ Date last normal period began
- _____ Age at first menstrual period
- _____ How many days between the start of one period until the start of the next period.

Amount of flow _____ Number of tampons per day _____
 Duration of flow () 1-3 days () 4-6 days () 7 or more days
 Cramps with period () none/mild () moderate () severe
 Premenstrual symptoms () none/mild () moderate () severe

- Circle One
 YES NO During the last 6 months have you had a period about once a month?
 YES NO Have you had any bleeding between periods?

BIRTH CONTROL HISTORY (CIRCLE ALL THAT APPLY)

- Diaphragm Cervical Cap Vaginal gels, foams
- Condom Tubal Ligation Vaginal suppositories
- Vasectomy (partner) Rhythm
- Fertility Awareness Basal Body Temperature
- Intrauterine device (type) _____
When Inserted _____
- Birth Control Pills Years taken _____ When did you stop _____
Brand Names _____

Are you currently using a method of birth control? _____
 If yes, what method? _____
 Have you had any problems with any method of birth control? _____
 If yes, please explain _____

PREGNANCY HISTORY

TOTAL NUMBER OF PREGNANCIES _____
 PRE TERM _____ FULL TERM _____ LIVING _____
 ABORTIONS _____ STILLBIRTHS _____
 ECTOPIC (Tubal) PREGNANCIES _____
 MISCARRIAGES _____ C-SECTIONS _____
 Number of children you have now _____
 Age at first pregnancy _____
 Date last pregnancy ended _____
 How? [] abortion [] miscarriage [] delivery
 [] Yes [] No Are you planning to have a child / children in the future?
 [] Yes [] No Do you think you could be pregnant now?

LIVE BIRTHS (COMPLETE IN ORDER OF DELIVERY)

#1 BORN (MO/YR) _____ Sex _____ Wt. _____ Hrs in Labor _____
 Weeks early/late _____ Epidural/anesthesia _____
 Hospital/City _____ Type of Delivery Vag / C-Sect _____
 Complications _____
 #2 BORN (MO/YR) _____ Sex _____ Wt. _____ Hrs in Labor _____
 Weeks early/late _____ Epidural/anesthesia _____
 Hospital/City _____ Type of Delivery Vag / C-Sect _____
 Complications _____
 #3 BORN (MO/YR) _____ Sex _____ Wt. _____ Hrs in labor _____
 Weeks early/late _____ Epidural/anesthesia _____
 Hospital/City _____ Type of Delivery Vag / C-Sect _____
 Complications _____
 #4 BORN (MO/YR) _____ Sex _____ Wt. _____ Hrs in labor _____
 Weeks early/late _____ Epidural/anesthesia _____
 Hospital/City _____ Type of Delivery Vag / C-Sect _____
 Complications _____
 **please list any complications such as birth defects, stillbirth, toxemia, diabetes, hemorrhage, infection, surgery, etc.

PAST HISTORY

- [] Yes [] No Do you think you are overweight?
- [] Yes [] No Does your weight often fluctuate 10-15 pounds?
- [] Yes [] No When dieting, do you starve yourself, make yourself vomit or take diuretics or laxatives to lose weight?
- [] Yes [] No Do you eat in binges or eat huge amounts of food at one time?
- [] Yes [] No Do you use seat belts?
- [] Yes [] No ARE YOU ALLERGIC TO ANY MEDICATIONS?
IF YES, WHAT MEDICATIONS? _____
- [] Yes [] No [] Unsure Did you mother take DES while pregnant with you?
- [] Yes [] No Do you smoke? How much? _____
_____ daily _____ Weekly _____ Monthly
- [] Yes [] No Do you use caffeine products? How much? _____
_____ daily _____ Weekly _____ Monthly
- [] Yes [] No Do you drink alcohol beverages? How much? _____
_____ daily _____ Weekly _____ Monthly
- [] Yes [] No Do you, or have you ever used IV drugs?
- [] Yes [] No Do you use recreational drugs?

SEXUAL HISTORY (This section is optional)

Age at first intercourse _____
 Is your sexual preference: _____ Heterosexual _____ Homosexual _____ Bisexual
 [] Yes [] No Are you sexually active now?
 [] Yes [] No Have you had more than one sexual partner in the past six months?
 [] Yes [] No Have you ever had a pelvic exam?
 [] Yes [] No Do you have any questions/concerns about sex you wish to discuss today?
 [] Yes [] No At any time in your life have you been involved in a sexual act that was against your will or has been frightening or painful?
 [] Yes [] No Are you in a relationship with a partner who physically hurts you (slaps, kicks, hits, pushes) or threatens you?

CURRENT AND RECENT MEDICATIONS: (include strength and frequency)

Prescription drugs:

Over-the-counter drugs:

FAMILY HISTORY

Were you adopted? [] Yes [] No

Have your blood relatives ever had any of the following?
If yes, who?

- [] Yes [] No Diabetes?
- [] Yes [] No Stroke?
- [] Yes [] No Heart attack or heart disease?
- [] Yes [] No High blood pressure?
- [] Yes [] No Breast cancer?
- [] Yes [] No Cancer of the cervix, uterus, ovary, colon, or pancreas?
- [] Yes [] No Kidney disease?
- [] Yes [] No Bleeding disorder?
- [] Yes [] No Mental illness?
- [] Yes [] No Did either parent die before age 50 from any of the above?

IMMUNIZATION RECORD

Please circle if immunized for any of the following
(include date given if known)

- _____ Flu
- _____ Hepatitis B
- _____ Tetanus
- _____ Pneumovax

HOSPITALIZATIONS

List all hospitalizations and surgeries (except for pregnancy)

Year _____	Reason _____	Place _____	Anesthesia problems? [] Yes [] No
Year _____	Reason _____	Place _____	Anesthesia problems? [] Yes [] No
Year _____	Reason _____	Place _____	Anesthesia problems? [] Yes [] No
Year _____	Reason _____	Place _____	Anesthesia problems? [] Yes [] No

MEDICAL HISTORY

Have you had any of these? If yes (Y), give the year. Circle Y or N

Yes	No	Year		Yes	No	Year	
Y	N	_____	Visual problems (not glasses)	Y	N	_____	Uterine abnormalities
Y	N	_____	Epilepsy (seizures)	Y	N	_____	Diabetes or gestational diabetes
Y	N	_____	Migraine headaches (doctor-diagnosed)	Y	N	_____	Anemia
Y	N	_____	Stroke	Y	N	_____	Bleeding tendency
Y	N	_____	Thyroid disease	Y	N	_____	Varicose veins
Y	N	_____	Breast lump	Y	N	_____	Cancer / where? _____
Y	N	_____	Asthma / respiratory problems	Y	N	_____	Hepatitis / jaundice
Y	N	_____	Pulmonary embolus (blood clot)	Y	N	_____	Gall bladder disease
Y	N	_____	Lung disease	Y	N	_____	Mononucleosis
Y	N	_____	Kidney disease / infection	Y	N	_____	Rheumatic fever
Y	N	_____	3 or more bladder infections	Y	N	_____	Heart murmur
Y	N	_____	Heart disease	Y	N	_____	Blood clots in legs
Y	N	_____	Mitral prolapse	Y	N	_____	Drug abuse
Y	N	_____	High blood pressure	Y	N	_____	Alcohol abuse
Y	N	_____	High cholesterol / blood fats	Y	N	_____	Psychiatric problems
Y	N	_____	Obesity	Y	N	_____	Suicide attempts
Y	N	_____	Gastrointestinal disorder	Y	N	_____	Severe depression
Y	N	_____	Sickle cell trait or disease	Y	N	_____	Breast surgery
Y	N	_____	Genitourinary disorder	Y	N	_____	Tuberculosis
				Y	N	_____	Other major illness / What?

GYNECOLOGIC HISTORY

Date of last pap _____ Where taken _____ Result _____

Have you had any of these?

Yes	No	Year		Yes	No	Year	
Y	N	_____	Abnormal pap smear	Y	N	_____	Syphilis
Y	N	_____	Gynecologic surgery or procedure	Y	N	_____	Chlamydia
Y	N	_____	Pelvic tumor / fibroids	Y	N	_____	Herpes
Y	N	_____	Infected tubes or uterus (PID)	Y	N	_____	Genital warts
Y	N	_____	Frequent vaginal infections	Y	N	_____	Gonorrhea
Y	N	_____	Other female organ problems - Explain _____	Y	N	_____	Infertility
				Y	N	_____	Trichomonas