

Patient Name: \_\_\_\_\_

**PAST HISTORY:** Check if you have ever had any of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Tuberculosis                 | <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Cancer                       |
| <input type="checkbox"/> Hernia                       | <input type="checkbox"/> Blood Disease               | <input type="checkbox"/> Hemorrhoids                  |
| <input type="checkbox"/> Bleeding Problem             | <input type="checkbox"/> Other Rectal problems       | <input type="checkbox"/> Heart Murmur                 |
| <input type="checkbox"/> Migraines                    | <input type="checkbox"/> Heart Disease               | <input type="checkbox"/> Kidney Disease               |
| <input type="checkbox"/> Ulcer of Stomach or Duodenum | <input type="checkbox"/> Pneumonia                   | <input type="checkbox"/> Kidney Infection             |
| <input type="checkbox"/> Frequent Bladder Infections  | <input type="checkbox"/> Hay Fever                   | <input type="checkbox"/> Epilepsy                     |
| <input type="checkbox"/> Sinus Trouble                | <input type="checkbox"/> Mental Disease              | <input type="checkbox"/> Measles                      |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Scarlet Fever               | <input type="checkbox"/> Asthma                       |
| <input type="checkbox"/> Mumps                        | <input type="checkbox"/> Gall Bladder Trouble        | <input type="checkbox"/> Thyroid Problem              |
| <input type="checkbox"/> Chicken Pox                  | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Serious Injuries             |
| <input type="checkbox"/> German Measles (3 day)       | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Ulcer of Stomach or Duodenum |
| <input type="checkbox"/> Polio                        | <input type="checkbox"/> Varicose Veins or Phlebitis | <input type="checkbox"/> Other                        |
| <input type="checkbox"/> Rheumatic Fever              | <input type="checkbox"/> Kidney Stones               |   |
| <input type="checkbox"/> Gestational Diabetes         | <input type="checkbox"/> Heart Disease               |   |

Do you have medication allergies? \_\_\_\_\_

Have you ever received a blood transfusion? \_\_\_\_\_

**HAVE YOU EVER HAD AN OPERATION ON ANY OF THE FOLLOWING? CHECK (X) IF YES:**

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> Appendix          | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Ectopic Pregnancy             |
| <input type="checkbox"/> Gall Bladder      | <input type="checkbox"/> Chest       | <input type="checkbox"/> Uterus                        |
| <input type="checkbox"/> Kidney Stones     | <input type="checkbox"/> Spine       | <input type="checkbox"/> Vaginal Repair                |
| <input type="checkbox"/> Tonsils           | <input type="checkbox"/> Breast      | <input type="checkbox"/> Cesarean Section              |
| <input type="checkbox"/> Tumor of any kind | <input type="checkbox"/> Ovary       | <input type="checkbox"/> Tubal ligation                |
| <input type="checkbox"/> Hernia            | <input type="checkbox"/> D & C       | <input type="checkbox"/> To treat urinary incontinence |

**FAMILY HISTORY:** Have your grandparents, parents, uncles, aunts, brothers, sisters or children ever had any of the following?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Osteoporosis  | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Ovarian Cancer     |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Kidney Trouble      | <input type="checkbox"/> Glaucoma           |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood Disease      |
| <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Hay Fever or Asthma | <input type="checkbox"/> Muscular Disorders |
| <input type="checkbox"/> Colon Cancer  | <input type="checkbox"/> Other Cancer        | <input type="checkbox"/> Blood Clots        |
| <input type="checkbox"/> Stroke        |  |   |

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### SOCIAL AND PERSONAL HISTORY:

1.  Single     Married     Separated

2. Occupation: \_\_\_\_\_

3. Do you use alcohol?     Yes     No    Tobacco?     Yes     No

4. Have you ever been sexually active?     Yes     No

5. Are you currently sexually active?     Yes     No

6. Do you now use some method of birth control?     Yes     No

Check method used:     IUD     Pill     Diaphragm     Condom     Rhythm     Withdrawal     Tubal ligation     Vasectomy

Frequency used:     Used Always     Used Most of the time     Used some of the time

7. Age at first intercourse?    \_\_\_\_\_

8. Sex with men/ women/ both     Men     Women     Both

9. Have you ever been diagnosed with an STD?     Yes     No

10. Have you ever felt that you were unsafe in your relationship?     Yes     No

### GYNECOLOGICAL HISTORY:

1. Age at first menstrual period    \_\_\_\_\_

2. Do you menstruate now?     Yes     No (Age at last period \_\_\_\_\_)

3. Periods are:     Monthly     Irregular

4. Approximately how many days from the beginning of one period to the beginning of the next?    \_\_\_\_\_

5. Periods usually last for a total of \_\_\_\_\_ days.

6. Do you ever have bleeding or spotting between periods?     Yes     No

7. Have you ever had a pap smear?     Yes     No

8. Date of last pap: \_\_\_\_\_ History of Abnormal Pap Smears? \_\_\_\_\_

9. Date last period began: \_\_\_\_\_ Date period before that began \_\_\_\_\_

10. Have you received the HPV vaccine (Gardasil)?    \_\_\_\_\_

11. What was the date of your last mammogram?    \_\_\_\_\_

12. What was the date of your last bone density scan?    \_\_\_\_\_

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**OBSTETRICAL HISTORY:**

- 1. How many times have you been pregnant? \_\_\_\_\_
- 2. How many full-term (9 month) babies have you had? \_\_\_\_\_
- 3. How many premature babies have you had? \_\_\_\_\_
- 4. How many miscarriages have you had? \_\_\_\_\_
- 5. How many living children do you have? \_\_\_\_\_
  
- 6. Have you ever had an ectopic pregnancy?  Yes  No
- 7. Were any of your pregnancies complicated?  Yes  No
  
- 8. Oldest child's age: \_\_\_\_\_ Youngest child's age: \_\_\_\_\_

**REVIEW OF SYSTEMS** Check if you have ever had any of the following:

- |  |   |
|--|---|
| <input type="checkbox"/> Sinus Pain                        | <input type="checkbox"/> Heartburn            |
| <input type="checkbox"/> Frequent or Severe Headaches      | <input type="checkbox"/> Muscle Pain/Weakness |
| <input type="checkbox"/> Fainting Spells / Dizziness       | <input type="checkbox"/> Joint Pain/Weakness  |
| <input type="checkbox"/> Rapid or Irregular Heartbeat      | <input type="checkbox"/> Joint Swelling       |
| <input type="checkbox"/> Chest Pain                        | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Frequent or Severe abdominal pain | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Frequent or Severe Indigestion    | <input type="checkbox"/> Mood Swings          |
| <input type="checkbox"/> Chronic or Recurrent Diarrhea     | <input type="checkbox"/> Excessive thirst     |
| <input type="checkbox"/> Chronic Constipation              | <input type="checkbox"/> Excessive Urination  |
| <input type="checkbox"/> Breast Problems                   | <input type="checkbox"/> Bruise Easily        |
| <input type="checkbox"/> Blood in Urine                    | <input type="checkbox"/> Anemia               |
| <input type="checkbox"/> Nausea or vomiting                | <input type="checkbox"/> Hot Flashes          |
| <input type="checkbox"/> Genital lesions/rashes            | <input type="checkbox"/> Night Sweats         |
| <input type="checkbox"/> Vision changes                    | <input type="checkbox"/> Difficulty Sleeping  |
| <input type="checkbox"/> Shortness of Breath               |   |
| <input type="checkbox"/> Palpitations                      |   |
| <input type="checkbox"/> Hearing Loss                      |   |
| <input type="checkbox"/> Bleeding gums                     |   |
| <input type="checkbox"/> Difficulty swallowing             |   |