1. Patient Identification (Please Print)

Patient's name: ______________________ Date of Birth: ____________ Age: ________

Address: ______________________ Marital Status: ____________

____

Home Telephone Number: ______________________ Employer: ______________________

Work Telephone Number: ______________________ Occupation: ______________________

Message Telephone Number: ______________________ Referring Physician: ______________________

2. Reason For Seeing Doctor:

____

____

____

3. Medical History

Have you or any members of your family had:

High Cholesterol.......................[ ] you [ ] family
Heart Disease..........................[ ] you [ ] family
Rheumatic Fever.......................[ ] you
High Blood Pressure..................[ ] you [ ] family
Asthma....................................[ ] you
Tuberculosis............................[ ] you
Diabetes..................................[ ] you [ ] family
Thyroid Problems.....................[ ] you [ ] family
Liver Disease...........................[ ] you
Stomach, Bowel, or
Gall Bladder Problems..............[ ] you
Kidney or Bladder Problems......[ ] you
AIDS (HIV)...............................[ ] you [ ] family
Hepatitis (type ____)................[ ] you [ ] family
Anemia or Blood Disorder..........[ ] you [ ] family

Blood Transfusion............[ ] you
Allergies...........................[ ] you
Breast Problems..............[ ] you [ ] family
Cancer...............................[ ] you [ ] family
Infertility...........................[ ] you
Female or Sexual Problems......[ ] you
Chlamydia...............................[ ] you
Gonorrhea...............................[ ] you
Herpes (HSV) ....[ ] you
Syphillis..................................[ ] you
Birth Defects or
Inherited Diseases............[ ] you [ ] family
Other Medical Problems....[ ] you [ ] family

4. Hospitalizations (*not including childbirth*)

Month/Year	Illness or Operation	Attending Physician	Complications

5. Pregnancy History

# of Pregnancies	# of Premature Births	# of Miscarriages	# of Induced Abortions	# of Living Children

# of term births	Born month/year	Baby's sex	Weight at Birth	Weeks Pregnant (term 40 wks)	Hours in Labor	Type of Delivery	Type of Anesthesia	Complications
1		M F						
2		M F						
3		M F						
4		M F						
5		M F						
6		M F						
7		M F						

6. Please answer the following questions by putting an (X) in the box next to the word Yes or No, except where you are asked for specific information.

If a question doesn't apply, skip it and go on to the next one.

Menstruation If you have not yet begun to menstruate, please begin with question 12.

1. How old were you when you first began menstruating?.._____years old
2. What was the first day of your last menstrual period?..____________
3. Are you past your menopause, or have you had a Hysterectomy? ....[ ] yes [ ] no
4. If Yes: Have you noticed any vaginal bleeding since?..[ ] yes [ ] no
   (Please skip to question 12)
5. Was your last menstrual period normal? ....[ ] yes [ ] no
6. How many days pass between the first day of each period? ....____ days pass
7. How long do your periods last? ...._____ days
8. On your heaviest day, how many pads and/or tampons do you use? ....____pads ___tampons
9. Are your periods usually painful? ....[ ] yes [ ] no
10. If Yes: Is the pain generally mild, moderate or severe? ....[ ] mild [ ] moderate [ ] severe
11. How do you treat your pain? ....Treat with ________________

Gynecology

12. Do you examine your breasts at least once a month? ....[ ] yes [ ] no
13. Have you noticed any discharge from your breasts? ....[ ] yes [ ] no
14. Have you noticed any change in the size of your breasts? ....[ ] yes [ ] no
15. Have you noticed any lumps or pain in your breasts? ....[ ] yes [ ] no
16. Have you ever had a mammogram? ....[ ] yes [ ] no
17. If yes: Write the month and year of your last test? ....____________

18. Have you had recurrent bladder infections? ....[ ] yes [ ] no
19. Are you bothered by frequent or painful urination? ....[ ] yes [ ] no
20. Do you have recurrent middle back pain? ....[ ] yes [ ] no

21. Have you had any recent vaginal itching or discharge? ....[ ] yes [ ] no
22. Have you ever had any infection in your tubes or ovaries? ....[ ] yes [ ] no
23. Have you ever had a Pap Smear? ....[ ] yes [ ] no
24. If Yes: Write in the month and year of your last test..____________
25. Have you ever had abnormal results from a Pap Smear? ....[ ] yes [ ] no
26. Did your mother ever take DES or any other hormones when she was pregnant with you?. ....[ ] yes [ ] no
27. Are you currently sexually active? ....[ ] yes [ ] no
28. If Yes: Do you have one or many partners? ....[ ] one [ ] many
29. Do you have pain with intercourse? ....[ ] yes [ ] no
30. Do you use birth control on a regular basis? ....[ ] yes [ ] no
31. What form of birth control have you and your partner used?....[ ] oral type__________ [ ] Depo Inj
    [ ] Lunelle Inj [ ] IUD [ ] Diaphragm
    [ ] Norplant [ ] Condoms

32. Do you have any questions about birth control? ....[ ] yes [ ] no
33. Have you ever had complications with any type of birth control? ....[ ] yes [ ] no
34. Do you have any questions about sexually transmitted diseases? ....[ ] yes [ ] no

35. Have you ever had any difficulty getting pregnant? ....[ ] yes [ ] no

Medications Now Taking Are you taking any of the following:

36. Antibiotics..[ ] yes [ ] no
37. Penicillin..[ ] yes [ ] no
38. Sulfa Drugs..[ ] yes [ ] no
39. Aspirin..[ ] yes [ ] no
40. Codeine/Demerol/Other pain medicine..[ ] yes [ ] no
41. Sedatives/tranquilizers..[ ] yes [ ] no
42. Birth Control Pills..[ ] yes [ ] no
43. Estrogen..[ ] yes [ ] no
44. Other Hormones..[ ] yes [ ] no
45. Blood Pressure medicines..[ ] yes [ ] no
46. Other medicines/vitamins..[ ] yes [ ] no
47. Are you allergic to or do you react poorly to any medicines? ....[ ] yes [ ] no
48. Are you a habitual user of any medicines or drugs? ....[ ] yes [ ] no

Please list any medications you are currently taking (include strength and dosing instructions) :

____
____
____
____
____
____
____
____

Substance Use:

50. Do you smoke cigarettes? ....[ ] yes [ ] no
51. If yes: How many packs per day do you smoke?.. ____________
52. Do you drink alcohol? ....[ ] yes [ ] no
52. If yes: How much alcohol do you consume in a week?.. ____________
53. How much caffeine do you consume in a typical day?.. ____________
54. Do you take any street drugs? ....[ ] yes [ ] no
55. If yes: What type of street drug do you use?.. ____________
56. How much do you use in a day?.. ____________

General Systems Review:

57. Do you have severe headaches more than once a week? ....[ ] yes [ ] no
58. Have you noticed any unusual hair growth or loss? ....[ ] yes [ ] no
59. Have you noticed any blood in your stools? ....[ ] yes [ ] no
60. Do you feel nervous or anxious on a daily basis? ....[ ] yes [ ] no
61. Do you feel lonely or depressed? ....[ ] yes [ ] no
62. Do you frequently have trouble sleeping? ....[ ] yes [ ] no
63. Are you concerned about work or family problems? ....[ ] yes [ ] no
64. Have you ever been treated for depression? ....[ ] yes [ ] no

Patients Signature: ____

Date: ____________________