

Preferred Name _____

Age _____

Occupation _____

Marital Status: Single Married Divorced/Separated Widowed Same Sex Partnership Opposite Sex Partnership**ANY CURRENT CONCERNS OR PROBLEMS** No Yes – please explain

MEDICAL HISTORY (include current, past, hospitalizations, major injuries, etc.) No change since last exam

SURGICAL HISTORY

OB/GYN HISTORY

of pregnancies _____ # of children _____ # of miscarriages/abortions _____

Age menses began _____ Last menstrual period _____

Frequency of menses _____ Length of periods _____ Pain Cramping with Menses No

Yes Describe _____

Any recent changes in periods _____

Any bleeding in the middle of your cycles or after intercourse? No Yes - Describe _____Are you currently sexually active? No Yes – with Male Female BothAny pain with intercourse? No Yes Sexual Issues? No Yes - Describe _____Do you need to use birth control? No Yes - What type _____Any history of sexually transmitted infections? No Yes - Describe _____Any vaginal concerns (itching, burning, discharge, odor)? No Yes – Please explain _____Have you had an abnormal PAP smear? No Yes If yes, when and what treatment did you have if any? _____**POST MENOPAUSE**Age of menopause? _____ Are you on hormones? No Yes If yes, how long? _____

Reason(s) for taking hormones? _____

Any vaginal bleeding? No Yes - Describe _____

Any menopausal symptoms:

 Hot flashes Night sweats Mood changes Vaginal dryness Urinary problems

Other _____

ALLERGIES

None Yes If yes, name and describe type of reaction:

HEALTH MAINTENANCE

Immunizations Current: Yes No

Cholesterol Date:_____ Thyroid (TSH) Date:_____

MEDICATIONS/ SUPPLEMENTS/ ALTERNATIVE THERAPIES

FAMILY MEDICAL HISTORY (breast, colon, uterine or ovarian cancer, heart disease, diabetes, osteoporosis, etc)

LIFESTYLE/HABITS

1. Do you exercise regularly? No Yes Type _____
minutes _____ # days per week _____
2. Calcium Intake: # of servings/ day _____. Do you take a supplement? No Yes
3. Do you eat a healthy diet? No Yes
4. Do you drink alcohol? No Yes # drinks per _____ (day/week/month).
Do you or anyone close to you think alcohol is a problem for you? No Yes
5. Tobacco use? Never Former (when did you quit?) _____
 Yes Currently smoking Do you want to quit? No Yes
6. Do you use recreational drugs? No Yes If so, what _____

REVIEW OF SYSTEMS (Any current problems with the following?)

1. **General**
 Weight loss Weight gain Headaches Fever Chills
 Sweats Fatigue Dizziness Fainting Eating problems Lumps
2. **Chest/Heart**
 Chest pain Palpitations Breathing problems Cough
3. **Breasts**
 Lumps Nipple discharge Pain
4. **Abdomen**
 Pain Indigestion Diarrhea Constipation Change in bowel habits
 Nausea Vomiting or blood in stools
5. **Urinary**
 Problems with urination Pain Bleeding Incontinence Frequency
6. **Emotional**
 Depression Anxiety Moodiness Irritability Insomnia Stress

Reviewed with patient by:

Date _____

Signature of Health Care Provider