NAME: ____ **DATE:** ____/____/____

BIRTHDATE: ____/____/____ **AGE:** _____________

NAME PREFERRED TO BE CALLED: __________________________________

REFERRED BY: ____

REASON FOR VISIT: ☐ **ANNUAL** ☐ **PROBLEM**

DESCRIBE PROBLEM: ____

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:					
DRUG NAME	DOSAGE	PHYSICIAN	DRUG NAME	DOSAGE	PHYSICIAN
ALLERGIES TO MEDICATIONS / SUBSTANCES (LATEX GLOVES, ETC.?)		List:			

GYN	YES	NO		YES	NO
Anemia			Hepatitis / Jaundice		
Anxiety			Herpes / HSV		
Arthritis / Joint pain			High Blood Pressure		
Asthma			High Cholesterol		
Blood transfusions			HIV / AIDS		
Breast Cancer			Kidney Infections / Urinary Tract Infections		
Cancer (Please specify)			Kidney Stones		
Chlamydia			Pneumonia		
Chronic Lung Disease			Rheumatic Fever		
Depression			Mood Disorders		
Diabetes (please specify)			Stroke		
Eating Disorder (please specify)			Syphilis		
Fracture			Tuberculosis - TB		
Gastrointestinal problems (please specify)			Tubal Ligation		
Glaucoma			Thyroid Disease(please specify)		
Gonorrhea / GC			Ulcers		
Heart problems			OTHER:		

GYN	CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:		
MAJOR ILLNESSES	YES	NO	WHAT BLOOD RELATIVE: Mother's / Father's
Anemia			
Arthritis/Joint Pain			
Asthma			
Bowel Trouble/Ulcers			
Breast Cancer			
Cancer			
Chronic Lung Disease			
Depression/Anxiety/Mood Disorders			
Diabetes			
Glaucoma			
Heart Trouble/Murmur			
Hepatitis/Jaundice			
High Blood Pressure			
High Cholesterol			
Kidney Infections/Stones			
Stroke			
Thyroid Disease			
Tuberculosis – TB			
OTHER:			

GYN	WHEN WAS YOUR LAST TEST OR IMMUNIZATION?		
Flu Shot	DATE		DATE
Pneumonia		T B Skin Test	
Chicken Pox		Tetanus	

PLEASE LIST ANY PAST INJURIES OR ILLNESSES:			
TYPE	DATE	TYPE	DATE

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:			
SURGERY / HOSPITALIZATION / REASON	DATE	SURGERY / HOSPITALIZATION / REASON	DATE

YOUR OB HISTORY	NUMBER		NUMBER
Total # of pregnancies		Full term births	
Premature delivery (less than 37 weeks)		Abortions / Termination	
Miscarriages		Living children	

YOUR GYN HISTORY

Are you using birth control? ☐ Yes ☐ No

❑ Condoms	❑ Nuvaring
❑ Depo Provera	❑ Birth Control Patch
❑ Diaphragm	❑ None
❑ IUD- Kind	❑ Natural Family Plan/Rhythm
- Date Inserted:	❑ Tubal Ligation
❑ Birth Control Pill	❑ Vasectomy
– Name:	❑ Withdrawal
❑ Contraceptive Foam/Jelly	❑ Other:

What tests have you had done and when?

Bone Density ____________________ Mammogram________________________

Colonoscopy/Sigmoidoscopy _______________________ Last Normal PAP Smear ________________________

Last abnormal Pap smear ______________________

Previous treatment of abnormal Pap __________________________

What age did you have your first period: ______________

How many days are there from start of your period to start of next period? ________ days

How long does your period last? _______ days Flow: ☐ Light ☐ Medium ☐ Heavy

Date of Last Period: _________________ Are you sure of the date? ☐ Yes ☐ No

Was it a normal period? ☐ Yes ☐ No

GYN

NAME: ____

BIRTHDATE: _____/_____/_______

PLEASE LIST HABITS			
Do you use a seat belt?	☐ Yes ☐ No		
Do you do a Self Breast Exam?	☐ Yes ☐ No	How often:_______________	
Do you Exercise? ☐ None ☐ Less than 3 times per week ☐ More than 3 times per week			
Smoking	☐ Yes ☐ No ☐ Previously		
Packs per day: _________	Number of Years: ______	Stopped _________ Years ago	
Alcohol ☐ Yes ☐ No ☐ Previously			
Drinks per day: _________	Drink per week: _________		
Drug User	☐ Yes ☐ No ☐ Previously		
Kind:	Frequency:		
History of abuse	☐ Yes ☐ No		
☐ Physical ☐ Emotional ☐ Sexual			
Occupation:			
Race ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ Other _______________			
Marital Status	☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed		