Today's Date:_____/_____/_____ Name: ____ DOB:_____ /_____/_____

What are you here for today?______________________________ Who is your Primary Care Provider?___________________

Are you allergic to any medications, metals, products, anesthesia and/or latex? List name and reaction:
____
____

Are you currently taking any medications (including herbal remedies and vitamins)List:______________________________
____
____
____

Menstrual History:

Duration of Flow (days):____________ Last Menses: ____________Frequency of Cycle(ie:28 or 30 days)_____________

Are your periods (circle): Regular Irregular Heavy

Is your Flow (circle): Light Moderate Heavy

At what age did you start your period? ___________

Current birth control method:_____________________________

Are you currently pregnant: Y N

Were you on Birth Control at Conception? Y N

If postmenopausal, age of Menopause: ___________

Date of last Mammogram: __________________

History of Abnormal Mammogram? Y N

Date of last PAP? _______________

History of abnormal PAP? Y N

Do you have uterine anomaly? Y N

Gardasil Vaccination? Y N

Are you sexually active? Y N

Number of partners in the last year: ________ Female / Male / Both

Have you ever had (circle): HPV / Warts / Chlamydia / Herpes / GC / Syphilis / PID

Pregnancy History:

Number of Pregnancies : ______________________

Number of Live births: ______________________

Number of Premature births: ___________________

Number of Miscarriages:_____________________

Number of Ectopic (tubal): _____________________

Number of Abortions: _______________________

Number of Multiples: _________________________

Number of Living Children: _________________

Surgical History: Procedure Date

____
____
____
____
____

Family History:

Relative Problem Onset Age Age Died

____
____
____
____
____
____

Social History:

Do you smoke? Y N If Yes circle: Every day Former Smoker

Do you have an Advanced Directive (living will) ? Y N

Drink Alcohol? Y N If yes circle: Occasional Heavy

Caffeine Intake? Y N If yes circle: Occasional Heavy

Use Illicit Drugs? Y N If yes circle: Occasional Heavy

Occupation: ____

Education Level: High School 2yr College Post Graduate

Exercise? Y N If yes circle: Occasional Heavy

Single or multi-level home / work? ____________________________

Live alone or with others? ___________________________________

Use Chewing Tabacco: Y N

Have you had any of the following problems with a pregnancy?
(circle all that apply)

Gestational Diabetes Preterm Labor

Genetic Abnormalities High Blood Pressure

Past Medical History (circle all that apply)

Acne Anemia Anesthesia Complications Anxiety Disorder Arthritis Asthma

Autoimmune disease Birth Defects Blood Disorders Breast Cancer Breast Problem COPD

Cancer ________________________ Coronary Artery Disease DVT (Deep Vein Thrombosis) Depression

Diabetes Diverticulitis Endometriosis Epilepsy Fibromyalgia GERD/Refulx

GI Problem Gall Bladder Disease Headaches Heart Disease Hepatitis High Blood Pressure

High Cholesterol HIV H/O Blood Transfusion Hypertension Hyperthyroidism

Hypothyroidism Infertility Kidney Disease Kidney Stones Kidney or Bladder Problems

Liver Disease Lung Disease Migraines Osteoporosis Ovarian Cancer

Psychiatric Illness Pulmonary Embolism Stroke Seasonal Allergies Skin – Other_________________

Thyroid Problems Tuberculosis Varicosities