ALL AREAS MUST BE FILLED OUT COMPLETELY

Today's Date ______/______/_______ Patient's Name ____

DOB ______/______/_______ Age ___________ Marital Status ___________________ Referring MD ______________________

Primary Care Physician __________________________ Date last seen by PCP ______________________________

Are you fasting today (nothing to eat or drink except water for past 8 hours) □ Yes □ No

Reason for the visit:

____

____

Medical History

Were **YOU** ever diagnosed with any of the following? Please check if yes:

□ Bleeding Disorders	□ Breast Cancer	□ High Blood Pressure	□ Cancer-Other
□ Hypothyroidism	□ Cervical Cancer	□ Arrhythmias	□ Polycystic Ovary Syndrome
□ Depression	□ Ovarian Cancer	□ Heart Murmur	□ Hepatitis
□ Asthma	□ Uterine Cancer	□ Diabetes	□ HPV
□ DVT/Pulmonary Embolism	□ Gestational Diabetes	□ HIV / AIDS	□ STD
□ Post-partum Depression	□ Infertility	□ Anesthesia Complication	□ History of Chickenpox
□ Anxiety	□ High Cholesterol	□ Stroke	□ Heart Problems
□ Thyroid Problems	□ Gastrointestinal Issues	□ Migraines	□ Anemia
□ Seizures/Epilepsy	□ Osteoporosis	□ Osteopenia	□ Autoimmune Disease

□ Other ____

Current Medications: Please list current medications, dosages, and frequency. Include non-prescription, occasionally used medication (i.e. Tylenol, Advil, etc.), and vitamins. **If none please put N/A**.

Medication Names:	**Dosage and Frequency**:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Herbal Supplements:	**Dosage and Frequency:**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Medication Allergies: Please list any allergies to medication, latex, anesthesia, or dye and reactions you have to these medications. **If none please put N/A**.

Medication Name:	**Reaction to Medication:**
______________________	______________________
______________________	______________________
______________________	______________________

Gynecologic History: **Please check one for each**

Age of First Period ______________________

How many days apart are your periods? ____________

How many days do your periods last? ____________

Are your periods regular, once a month? ☐ **Yes** ☐ **No**

Do you have excessively heavy periods? ☐ **Yes** ☐ **No**

Do you have leakage of urine? ☐ **Yes** ☐ **No**

Do you have pain with urination? ☐ **Yes** ☐ **No**

Do you have vaginal itching or burning? ☐ **Yes** ☐ **No**

Do you have hot flashes/night sweat? ☐ **Yes** ☐ **No**

Do you have breast problems? ☐ **Yes** ☐ **No**

Prior History of Abnormal Pap Smear ☐ **Yes** ☐ **No**

Prior History of Abnormal Mammogram ☐ **Yes** ☐ **No**

Have you received the Gardasil Vaccine? ☐ **Yes** ☐ **No**

Sexually Active: ☐ **Yes** ☐ **Not currently** ☐ **Never**

☐ **with Men** ☐ **with Women** ☐ **with Both**

Do you have excessive cramping with your periods? ☐ **Yes** ☐ **No**

Do you have bleeding in between your periods? ☐ **Yes** ☐ **No**

Do you have pain with intercourse: ☐ **Yes** ☐ **No**

Do you have frequency/urgency of urination? ☐ **Yes** ☐ **No**

Do you have pelvic pain? ☐ **Yes** ☐ **No**

Do you have abnormal discharge? ☐ **Yes** ☐ **No**

Do you have vaginal dryness? ☐ **Yes** ☐ **No**

Current Contraception: ☐ **None** ☐ **Condom** ☐ **Pills** ☐ **Patch** ☐ **Vaginal Ring** ☐ **IUD** ☐ **Depo-provera** ☐ **Implanon** ☐ **Diaphragm** ☐ **Tubal Ligation** ☐ **Vasectomy**

If Yes, When did you receive the vaccine? ____________

Last Period: ____/____/____ ☐ Never

Last Pap Smear: ____/____/____ ☐ Never

Last Mammogram: ____/____/____ ☐ Never

Last Colonoscopy: ____/____/____ ☐ Never

Last Bone Density: ____/____/____ ☐ Never

Obstetric **If none please put N/A**

Pregnancies __________ Abortions __________ Miscarriages __________ Ectopic __________ Living __________

Pregnancy #1 Date of Delivery__________ # of Weeks __________ Sex __________ Birth Weight __________

Type of Delivery __________ Place of Delivery __________ Complications __________

Pregnancy #2 Date of Delivery__________ # of Weeks __________ Sex __________ Birth Weight __________

Type of Delivery __________ Place of Delivery __________ Complications __________

Pregnancy #3 Date of Delivery__________ # of Weeks __________ Sex __________ Birth Weight __________

Type of Delivery __________ Place of Delivery __________ Complications __________

Pregnancy #4 Date of Delivery__________ # of Weeks __________ Sex __________ Birth Weight __________

Type of Delivery __________ Place of Delivery __________ Complications __________

Surgical/Hospitalization History: Please List any surgical procedures or hospital stays along with the month/year.

If none please put N/A.

Month/Year	Reason/Procedure
______/______	____
______/______	____
______/______	____
______/______	____
______/_____	____
______/_____	____

Social History: **Please circle one for each and fill in the blank**

Smoking Current / Previous / Never Number of years ________ Packs/Day _________ Year Quit __________

Alcohol Regular / Moderate / Social / Occasional / Never Drinks/Week ______________________________

Illegal/Recreational Drugs Current / Previous / Never Specify Type of Drug _______________________________

Medications/Illicit/Recreational drugs/alcohol since last menstrual period Yes/No

If yes, Agent(s) and strength/dosage____

Exercise Regular / Occasional / None Type and Frequency ______________________________

Calcium Intake (includes drinking milk and eating yogurt) Good / Minimal / None

Diet Regular/Vegetarian/Pescatarian/Vegan/Dairy Free/Gluten Free Other: _____________________

Caffeine Intake Yes/No If so, Type and Daily Amount (ex: Coffee, Tea, Chocolate, etc…) ________________________

Domestic Violence/Sexual Abuse____

Occupation ____

Do you always wear your seatbelt when in a motor vehicle? Yes/No

Do you live or work around cats or dogs? Yes/No

Do you:

Live with someone with TB or exposed to TB	Yes	No
Or your partner have genital herpes	Yes	No
Rash or viral illness since last menstrual period	Yes	No
History of STD, Gonorrhea, Chlamydia, HPV, Syphilis	Yes	No

Family History: Please check the follow that apply to **YOUR FAMILY** (**BLOOD RELATIVES** on both your mother and father's side) and if they are living or deceased. If they are deceased, please list the age at the time of death as well as cause of death.

	Mother	Maternal Grandmother	Maternal Grandfather	Father	Paternal Grandmother	Paternal Grandfather	Siblings	Other
Living?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	
Age								
High Blood Pressure								
Diabetes								
Heart Disease								
High Cholesterol								
Stroke								
Bleeding/Clotting Disorder								
Thyroid Disorder								
Autoimmune Disease								
Breast Cancer (please list age of diagnosis)								
BRCA Mutation Carrier								
Cervical Cancer (please list age of diagnosis)								
Ovarian Cancer (please list age of diagnosis)								
Endometrial/Uterine Cancer (please list age of diagnosis)								
Colon Cancer (please list age of diagnosis)								
Other Cancer, indicate type								
Other:								
Other:								
Other:								

Genetic History: **Please Circle one for each**

Do you or anyone in your family have a history of:

Thalassemia ....Yes No
Neural Tube Defect ....Yes No
Congenital Heart Defect...Yes No
Down Syndrome ....Yes No
Tay-Sachs..Yes No
Canavan Disease ....Yes No
Sickle cell disease or trait...Yes No
Ashkenazi Jewish ancestry ....Yes No
Hemophilia or other blood disorders ....Yes No
Muscular dystrophy ....Yes No
Cystic Fibrosis..Yes No
Intellectual Disability/Autism ....Yes No
    If yes, was person tested for fragile X..Yes No
Maternal metabolic disorder ....Yes No
Patient or baby's father had a child with birth defect not listed.............................Yes No
Recurrent pregnancy loss or a stillbirth ....Yes No
Other inherited genetic or chromosomal disorder ....Yes No
    If yes, please list____

Blood Transfusion:

In case of a medical emergency requiring transfusion of blood or blood products, please check one of the following:

☐ I Accept ☐ I Do NOT Accept

Patient Signature ____ **Date** _____/_____/______