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
□ Deep Vein Thrombosis	□ 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**	

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**

Last Period:	____/____/____	□ Never	Last Colonoscopy:	____/____/____	□ Never
Last Pap Smear:	____/____/____	□ Never	Last Bone Density:	____/____/____	□ Never
Last Mammogram:	____/____/____	□ 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
______/______	______________________________
______/______	______________________________
______/______	______________________________
______/______	______________________________
______/______	______________________________
______/______	______________________________

Family History: Please check the follow that apply to **YOUR FAMILY** (**BLOOD RELATIVES** on both your mother and father's side). Please list your relationship to the individual diagnosed.

- ☐ High Blood Pressure ____________________
- ☐ BRCA Mutation Carrier____________________
- ☐ Diabetes ____________________
- ☐ Heart Disease ____________________
- ☐ High Cholesterol ____________________
- ☐ Stroke ____________________
- ☐ Tuberculosis ____________________
- ☐ Bleeding Disorder ____________________
- ☐ Thyroid Disorder ____________________
- ☐ Hepatitis ____________________
- ☐ Autoimmune Disease ____________________
- ☐ Breast Cancer before age 50 ____________________
- ☐ Breast Cancer after age 50 ____________________
- ☐ Cervical Cancer ____________________
- ☐ Ovarian Cancer ____________________
- ☐ Endometrial/Uterine Cancer before age 50__________
- ☐ Endometrial/Uterine Cancer after age 50__________
- ☐ Other Cancer, indicate type ____________________ ____________________
- ☐ Birth Defects ____________________
- ☐ Genetic Disorders ____________________
- ☐ Other ____________________

Social History

Please Circle one for each

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 ____________________

Exercise Regular / Occasional / None Type and Frequency ____________________

Calcium Intake Good / Minimal / None

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

Domestic Violence/Sexual Abuse____________________

Do you live or work around cats or dogs ☐ Yes ☐ No

Genetic History

Please Circle one for each

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

Thalassemia .... Yes No
Neural Tube Effect.. 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
Mental Retardation/Autism .... Yes No
If yes, was person tested for fragile X .... Yes No
Other inherited genetic or chromosomal disorder .... 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
Medications/Illicit/Recreational drugs/alcohol since last menstrual period .. Yes No
If yes, Agent(s) and strength/dosage ____

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

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** _____/_____/______