

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Reason for today's visit**

\_\_\_\_\_

**Medical problems**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Surgeries**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies to medications or latex**

\_\_\_\_\_  
\_\_\_\_\_

**Medications**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Reproductive history**

Pregnancies—include date, type of delivery (vaginal, c-section, miscarriage, abortion), weight and gender if applicable, and any complications

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Age at first period \_\_\_\_\_

Cycle interval (from one cycle to next) \_\_\_\_\_

Length of period \_\_\_\_\_

Flow—light, medium, or heavy \_\_\_\_\_

Number of tampons \_\_\_\_ or pads \_\_\_\_ per day

Clots with period? \_\_\_\_\_

Bleeding between periods? \_\_\_\_\_

Last menstrual period \_\_\_\_\_

Method of birth control \_\_\_\_\_

If menopausal, age periods stopped \_\_\_\_\_

Taking hormones? \_\_\_\_\_

**Family history**—Has anyone in your family (parents, children, siblings, grandparents, aunts, or uncles) had any of these problems? At what age were they diagnosed with the problem?

Cancer of breast \_\_\_\_\_

Other family diseases \_\_\_\_\_

Cancer of female organs \_\_\_\_\_

Heart attack \_\_\_\_\_

Colon cancer  
\_\_\_\_\_

High cholesterol \_\_\_\_\_

Diabetes (type I or  
2) \_\_\_\_\_

Bleeding disorder \_\_\_\_\_

High blood pressure \_\_\_\_\_

Blood clot in legs/lungs \_\_\_\_\_

Stroke

Osteoporosis \_\_\_\_\_

Birth defects \_\_\_\_\_

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### Social history

What is your marital status? \_\_\_\_\_

At what age was your first intercourse? \_\_\_\_\_

What is your level of education? \_\_\_\_\_

How many sexual partners have you had in the last year?  
\_\_\_\_\_

Do you smoke—yes or no?

How much? \_\_\_\_\_

How many sexual partners have you had in your  
lifetime? \_\_\_\_\_

Do you drink alcohol—yes or no?

How much? \_\_\_\_\_

Have you ever had a sexually transmitted infection? If  
so, what type?  
\_\_\_\_\_

Do you use drugs—yes or no?

Which type? \_\_\_\_\_

Do you have any concerns about your sex life?  
\_\_\_\_\_

Do you exercise—yes or no?

How many hours per week? \_\_\_\_\_

Do you have any concerns about domestic violence?  
\_\_\_\_\_

### Do you have any of the following symptoms? Circle all that apply

fatigue

vomiting

significant PMS

fever

diarrhea

post-coital bleeding

chills

constipation

muscular weakness

body aches

blood in stools

incoordination

night sweats

urinary urgency

tingling or numbness

loss of appetite

frequent urination

joint pain

headaches

painful urination

muscle pain

breast lump

urination during the night

loss of hair

breast tenderness

incontinence or leaking urine

weight gain

breast swelling

decreased sex drive

weight loss

nipple discharge

painful intercourse

significant acne

chest pain

genital sores

facial hair growth

dizziness or passing out

irregular periods

anxiety

varicose veins

painful periods

depression

shortness of breath

heavy periods

feeling confused

wheezing

frequent periods

difficulty sleeping

cough

vaginal discharge

suicidal thoughts

nausea

absence of periods

excessive anger

For staff use only: Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_