Name____Age__________

Primary Care Provider________________________

Married Single Divorced Long Term Partner

Partner Name__________________________________ Occupation______________

Reason for visit today:____
____
____

Has anything changed with your health since your last visit?:____________________
____

Allergies:____

Medications:____
____
____

Medical Problems:____
____
____

GYN History

When was your last: Mammogram____________________PAP______________

Bone Density____________________Colonoscopy__________

Age you started your period?________Do you still get them? Yes No

Are they regular? Yes No

How often does it occur?__________How long does it last?_______

What was the first day of your last period?

Are your periods heavy? Yes No

Have you ever taken hormone replacement therapy?_______________________________

Have you ever had a GYN Procedure? (colposcopy, laparoscopy, ablation, etc.)______________

Abnormal PAP Smears?________________Fibroids?________________

Ovarian Cysts?______________________Breast problems?__________

Sexually transmitted infections? Gonorrhea Chlamydia Herpes Syphilis

Are you sexually active? Yes No Are you having any sexual problems?______________

Partners: Male Female Both_______Number of life time partners?________________

What do you use for birth control?________________________

Do you have children? Please list:

Birthdate	Weight	Sex	Weeks Pregnant	Type of delivery	Where	Any problems?

Miscarriages?________________________________Terminations?__________________________

Surgical History/ Dates:____

____

____

Family History- List relatives - Grandparents, Aunts, Uncles, (Maternal or Paternal) Siblings

High Blood Pressure?______________Heart Disease?_____________Diabetes?________________

Breast Cancer?____________________Ovarian Cancer?___________Colon Cancer?______________

Stroke?_________________________Blood Cots?______________Osteoporosis?______________

Lifestyle/Social

Do you practice self breast exams?____What exercise do you do?_________How often?___________

Do you smoke?_______How much?_________Do you drink alcohol?_______How often?___________

Do you use any drugs?_______How often?_________

Do you have any health concerns or questions?____

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Patient Signature____ Date__________________________

Provider Signature_______________________________________ Date__________________________