Date: _______________

Name: __________________________________D.O.B__________

Are you allergic to any medications/latex?______________________________ Your Height: _______

Menstrual History

Age of onset:_________________________

How often does cycle occur: _______________

How long does cycle last: ________________

Birth control: _________________________

Problems: ___________________________

Total number of sex partners:

Men:_______ Women: _______ Both: _______

Sexually Abused/Hurt?__________________

Substance Use (How much? How long?)

Tobacco_____________________________

Alcohol _____________________________

Recreational Drugs_____________________

Obstetrical History

Total number of pregnancies: ______________

Live Births: __________________________

Miscarriages: _________________________

Abortions: ___________________________

Adoptions: ___________________________

Past Medical History

High Blood Pressure
Heart Disease/Murmurs
Mitral Valve Prolapse
TB/Asthma
Rheumatic Fever
Diabetes
Bowel Problems
Liver Disease/Hepatitis

Kidney Disease/Stones
Urinary Infections
Thyroid Problem
Broken Bones
Bleeding Disorder
Anemia
Blood Clots (Legs/Lungs)
Blood Transfusions

Epilepsy/Seizures
Arthritis
Lupus
Collagen Vascular disease
Breast Problems
Infertility
Depression/Anxiety
Abnormal Paps
Trauma/Violence

Operations/Hospitalizations/Anesthesia complications:______________________________

____

____

Family History

Mother Age: Living/Deceased Cause: ______________________________

Father Age: Living/Deceased Cause: ______________________________

Heart Disease: ______________ Diabetes: ______________ Breast, Uterine,

Stroke: ______________ Cholesterol: ______________ and/or Ovarian

High Blood Pressure: ______________ Osteoporosis: ______________ Cancer: ______________

Blood Clots (Legs/Lungs): ______________ Colon Cancer: ______________ ______________

Infection History:

High Risk for HIV______ High Risk for Hepatitis B______ Chicken Pox______ TB Exposure______

Patient or partner has a history of genital herpes, chlamydia, syphilis, or genital warts:

______________________________ If herpes, how often? ______________

Vaccinated:

German Measles____ Measles____ Chicken Pox____ Hepatitis B____ Tetanus Booster____ Flu Shot ____

Date of Last:

Mammogram ______________ Bone Density ______________ Colonoscopy ______________

Please list any medications, hormones, vitamins, herbal products or birth control you take:

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