WOMEN'S HEALTHCARE OF TRUMBULL

Name_____ Today's Date_____

How did you hear about our practice? _____

Reason for Today's visit: Routine Annual Exam: Y N
Issues you would like to discuss_____

Medications you currently take:_____
_____

Personal Medical History:_____
Current Weight (in lbs)_____Current Height (in ft/in) _____

Are you allergic to any medications? N Y: Medication?_____If yes, the reaction was_____

GYN History: Date of last Pap smear:_____
Have you ever had problems with Pap in the past? Y N
If yes what treatment was needed:_____

Do you menstruate regularly: Y N
First Day of Last Menstrual Period: _____
Age when your periods stopped: _____

OB History: # of Pregnancies you have had: _____Ages: _____

 # Live births:_____ # Miscarriages:_____#Abortions:_____#Adoptions:_____

Surgical History:_____

Have you ever been hospitalized for any other reason: N Y; why?_____

Family History: Father: alive Y N; if deceased, at what age___Health Problems:_____
Mother: alive Y N; if deceased, at what age___Health Problems:_____
Siblings: alive Y N; if deceased, at what age___Health Problems:_____
Family History: Breast cancer: Y N Ovarian Cancer: Y N Colon Cancer: Y N

If yes who?_____ If yes who?_____If yes who?_____

Social History: Do you smoke cigarettes: Y N Did you smoke in the past: Y N
How many times per week do you drink alcohol? _____and how many drinks at a time? _____
Are you currently sexually active: Y N with men with women with both
Do you want to be tested for Sexually Transmitted Infections? Y N

Do you exercise? Y N

What is your current occupation? _____
Do you wear a seatbelt in the car? Y N
Have you ever been the victim of violence? Y N_____