

Name:

Date:

Age:

MENSTRUAL HISTORY:		LIST PREGNANCIES (Including Miscarriages)				
Age at onset: _____		Year	Weight	Sex	Hrs. Labor	Complications
Regular: <input type="checkbox"/> YES <input type="checkbox"/> NO						
Cycle: _____ days (from start to end)						
Usual duration: _____ days						
Flow: <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy						
Pains or cramps: <input type="checkbox"/> YES <input type="checkbox"/> NO						
Date of last period: _____						
What Birth Control Method are you using? <input type="checkbox"/> Pill <input type="checkbox"/> IUD <input type="checkbox"/> Diaphragm <input type="checkbox"/> Foam/Suppository <input type="checkbox"/> Condom <input type="checkbox"/> Other:						
If you are taking Birth Control Pills?				Allergies:		
Brand:						
When did you last have an internal pelvic exam?				Medications:		
When did you last have a pap test? (cancer smear)						
Have you ever had a suspicious pap smear? <input type="checkbox"/> YES <input type="checkbox"/> NO				Transfusion:		
Have you ever had a Biopsy? <input type="checkbox"/> YES <input type="checkbox"/> NO						
<input type="checkbox"/> Breast <input type="checkbox"/> Cervix <input type="checkbox"/> D&C				Hospitalization and surgery:		
Have you ever had laser or freezing? <input type="checkbox"/> YES <input type="checkbox"/> NO						
<input type="checkbox"/> Cervix <input type="checkbox"/> Vagina				Serious medical problems:		
HAVE YOU EVER HAD ANY OF THE FOLLOWING WITHIN TH PAST YEAR:				HAVE YOU EVER HAD:		
Any excessively heavy periods <input type="checkbox"/> YES <input type="checkbox"/> NO				History of maternal DES exposure: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Any bleeding between periods <input type="checkbox"/> YES <input type="checkbox"/> NO				Pelvic inflammatory disease <input type="checkbox"/> YES <input type="checkbox"/> NO		
Any bleeding after intercourse <input type="checkbox"/> YES <input type="checkbox"/> NO				Herpes <input type="checkbox"/> YES <input type="checkbox"/> NO		
Any unusual pain with intercourse <input type="checkbox"/> YES <input type="checkbox"/> NO				Syphilis <input type="checkbox"/> YES <input type="checkbox"/> NO		
Any blood in your urine <input type="checkbox"/> YES <input type="checkbox"/> NO				Gonorrhea <input type="checkbox"/> YES <input type="checkbox"/> NO		
Any persistent or unusual pain or burning when urinating <input type="checkbox"/> YES <input type="checkbox"/> NO				Genital Warts <input type="checkbox"/> YES <input type="checkbox"/> NO		
Any persistent lumps in your breasts <input type="checkbox"/> YES <input type="checkbox"/> NO				Chlamydia <input type="checkbox"/> YES <input type="checkbox"/> NO		
Any bleeding from the nipple <input type="checkbox"/> YES <input type="checkbox"/> NO				AIDS <input type="checkbox"/> YES <input type="checkbox"/> NO		
Any rectal bleeding, constipation or diarrhea <input type="checkbox"/> YES <input type="checkbox"/> NO				Other sexually transmitted diseases <input type="checkbox"/> YES <input type="checkbox"/> NO		
Any loss of urine with cough or sneeze <input type="checkbox"/> YES <input type="checkbox"/> NO						
Any night sweats, hot flashes <input type="checkbox"/> YES <input type="checkbox"/> NO						
PERSONAL HEALTH HISTORY						
Height _____ Weight _____ Weight one year ago _____ Highest weight _____ When _____						
HAVE YOU HAD ANY OF THE FOLLOWING				DO YOU NOW HAVE OR HAVE YOU EVER HAD?		
Asthma <input type="checkbox"/> YES <input type="checkbox"/> NO				Any eye disease, injury, impaired sight <input type="checkbox"/> YES <input type="checkbox"/> NO		
Pneumonia <input type="checkbox"/> YES <input type="checkbox"/> NO				Any ear disease, injury, impaired hearing <input type="checkbox"/> YES <input type="checkbox"/> NO		
Rheumatic fever <input type="checkbox"/> YES <input type="checkbox"/> NO				Any head injury, fainting spells, convulsions <input type="checkbox"/> YES <input type="checkbox"/> NO		
Heart disease <input type="checkbox"/> YES <input type="checkbox"/> NO				Frequent or severe headaches <input type="checkbox"/> YES <input type="checkbox"/> NO		
Heart Murmur <input type="checkbox"/> YES <input type="checkbox"/> NO				Skin disease <input type="checkbox"/> YES <input type="checkbox"/> NO		
Polio or meningitis <input type="checkbox"/> YES <input type="checkbox"/> NO				Chronic or frequent cough <input type="checkbox"/> YES <input type="checkbox"/> NO		
Kidney infection <input type="checkbox"/> YES <input type="checkbox"/> NO				Chest pain, or spitting up blood <input type="checkbox"/> YES <input type="checkbox"/> NO		
Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO				Shortness of breath <input type="checkbox"/> YES <input type="checkbox"/> NO		
Anemia <input type="checkbox"/> YES <input type="checkbox"/> NO				Swelling of hands, feet, or ankles <input type="checkbox"/> YES <input type="checkbox"/> NO		
Jaundice or hepatitis <input type="checkbox"/> YES <input type="checkbox"/> NO				Varicose veins <input type="checkbox"/> YES <input type="checkbox"/> NO		
Gallbladder Disease <input type="checkbox"/> YES <input type="checkbox"/> NO				Kidney or bladder disease <input type="checkbox"/> YES <input type="checkbox"/> NO		
Epilepsy <input type="checkbox"/> YES <input type="checkbox"/> NO				Indigestion, stomach trouble, or ulcer <input type="checkbox"/> YES <input type="checkbox"/> NO		
Migraine headaches <input type="checkbox"/> YES <input type="checkbox"/> NO				Alcoholic beverages <input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Daily		
Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO				Cigarettes: _____ packs per day		
Valley Fever <input type="checkbox"/> YES <input type="checkbox"/> NO				Drug usage: <input type="checkbox"/> YES <input type="checkbox"/> NO Last used:		
Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO						
Nervous breakdowns <input type="checkbox"/> YES <input type="checkbox"/> NO						
PLEASE CIRCLE:						
Race: Hispanic, Asian, White, Black, Native- American, Multiracial, (OR) Other:						
Ethnicity: Arab, Armenian, Belarus, Chinese, Cuban, English, Filipino, German, Greek, Hispanic-Latino, Hindi, Hmong, Indian, Japanese, Jewish, Laotian, Mein, Persian, Puerto Rican, Romanian, Russian, Thai, Ukrainian, Vietnamese, (OR) Other:						
FAMILY MEDICAL HISORY – HAS ANY RELATIVE EVER HAD (Please circle):						
Cancer TB Heart Trouble High Blood Pressure Stroke Epilepsy Hysterectomy Caesarian Section Kidney trouble						