

NAME: _____

DATE _____

AGE: _____

MENSTRUAL HISTORY

Age at onset _____
 Regular: Yes No
 Cycle: _____ days (from start to start)
 Usual duration: _____ days
 Flow: Light Moderate Heavy
 Pains or cramps: Yes No
 Date of last period _____

LIST PREGNANCIES (Include Miscarriages)

Year	Weight	Sex	Hrs of Labor	Complications

What Birth Control method are you using?

Pill IUD Diaphragm Foam/Suppository Condoms Other: _____

If you are taking Birth Control Pills?

Brand: _____

Allergies: _____

When did you last have an internal pelvic examination?

Medications: _____

When did you last have a pap test (Cancer smear)

Have you ever had a suspicious pap smear? Yes No

Serious medical problems: _____

Have you ever had a biopsy? Yes No

Breast Cervix D&C

Hospitalizations and Surgery: _____

Have you ever had laser or freezing? Yes No

Breast Vagina

Transfusions: _____

HAVE YOU HAD ANY OF THE FOLLOWING WITHIN THE PAST YEAR

HAVE YOU EVER HAD

Any excessively heavy periods Yes No

History of maternal DES exposure Yes No

Any bleeding between periods Yes No

Pelvic inflammatory disease Yes No

Any bleeding after intercourse Yes No

Herpes Yes No

Any unusual pain with intercourse Yes No

Syphilis Yes No

Any blood in your urine Yes No

Gonorrhea Yes No

Any persistent or unusual pain or burning when urinating Yes No

Genital Warts Yes No

Any persistent lumps in your breasts Yes No

Chlamydia Yes No

Any bleeding from the nipple Yes No

AIDS Yes No

Any rectal bleeding, constipation or diarrhea Yes No

Other sexually transmitted diseases Yes No

Any loss of urine with cough or sneeze Yes No

Any night sweats, hot flashes Yes 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 Yes No

Any eye disease, injury, impaired sight Yes No

Pneumonia Yes No

Any ear disease, injury, impaired hearing Yes No

Rheumatic fever Yes No

Any trouble with nose, sinuses, mouth, throat Yes No

Heart disease Yes No

Any head injury, fainting spells, convulsions Yes No

Heart murmur Yes No

Frequent or severe headaches Yes No

Polio or meningitis Yes No

Skin disease Yes No

Diabetes Yes No

Chronic or frequent cough Yes No

Anemia Yes No

Chest pain, or spitting up blood Yes No

Jaundice or hepatitis Yes No

Shortness of breath Yes No

Gallbladder disease Yes No

Swelling of hands, feet, or ankles Yes No

Epilepsy Yes No

Varicose veins Yes No

Migrain headaches Yes No

Kidney or bladder disease Yes No

Tuberculosis Yes No

Indigestion, stomach trouble, or ulcer Yes No

Valley Fever Yes No

Alcoholic beverages Never Occasional Daily

Cancer Yes No

Cigarettes _____ packs per day No

Nervous breakdown Yes No

Drug usage _____ Last used _____

FAMILY MEDICAL HISTORY - HAS ANY RELATIVE EVER HAD: (Please circle)

Cancer T.B. Diabetes Heart Trouble High Blood Pressure Stroke Epilepsy Hysterectomy Caesarian Section Kidney Trouble