Date:_____

Patient Name:_____Patient Date of Birth:_____

Have you ever had a Mammogram ☐Yes☐No If yes when? _____

Date of last PAP SMEAR_____Date of last Menstrual Period_____

Age of first period_____How heavy is your flow? _____

How many days from the beginning of one period to the next? _____

Are you sexually active? ☐Yes☐No Do you have pain with intercourse? ☐Yes ☐No

What is your present method of birth control? _____

For patients ages 12-26, have you received the Gardasil (Human Papilloma Virus) Immunization? Yes or No (see below)

☐ **If No**, have you ever received information on the Gardasil Immunization (Human Papilloma Virus)? **Yes or No (circle one)**

☐ **If Yes**, When did you complete all three injections?_____

Are you allergic to any medications? ☐Yes☐No ☐Penicillin ☐ Codeine ☐Iodine ☐ Tape ☐ Other _____

List all medications that you are presently taking: _____

_____

Total Pregnancies:	How many?	List year for each:
Full-Term		
Pre-term		
Living		
Adopted		
Miscarriage		
Abortion		

Have you ever had Surgery? ☐Yes ☐No If yes what and when? Explain: _____

_____

Have you ever been in any major Accidents/Hospitalizations? ☐Yes ☐No If yes, Explain: _____

_____

Level of Education: Grade school_____ High School_____College_____***Post Graduate*****_____**

PLEASE TURN PAGE OVER

FAMILY HISTORY: PLEASE LIST BELOW IF YOU OR ANYONE IN YOUR FAMILY HAS HAD ANY OF THE FOLLOWING:

SELF	***Condition: CHECK BELOW***	***Family Member***	***(FATHER SIDE) LIST below Father , sister ,brother, aunt, uncle, grandparent***	***(MOTHER SIDE) List below Mother, sister ,brother, aunt, uncle, grandparent***
☐	Asthma	☐		
☐	Cancer: (specify, what kind)	☐		
☐	Diabetes	☐		
☐	Endometriosis	☐		
☐	Epilepsy	☐		
☐	Fibroids	☐		
☐	Heart Disease or Murmur	☐		
☐	Hepatitis	☐		
☐	High Blood Pressure	☐		
☐	High Cholesterol	☐		
☐	Kidney/Liver Disease	☐		
☐	Lung Problems: (specify)	☐		
☐	Migraine Headaches	☐		
☐	Musculature: (specify)	☐		
☐	Nervous Condition	☐		
☐	Severe Depression	☐		
☐	Skeletal issues:(specify)	☐		
☐	Stroke	☐		
☐	Suicidal Thoughts	☐		
☐	Thyroid Condition	☐		
☐	Ulcers	☐		
☐	Other: (specify)	☐		
☐	Other: (specify)	☐		
☐	Other: (specify)	☐		

Do <u>YOU</u> have or have you had any of the following:

☐ ***Anemia***	☐ ***Hemorrhoids***	☐ ***HIV***	☐ ***Chlamydia***
☐ ***Blood Transfusions***	☐ ***Infertility***	☐ ***Herpes***	☐ ***Crabs***
☐ ***Urinary Tract Infection***	☐ ***Painful Periods***	☐ ***Syphilis***	☐ ***Trichomonas***
☐ ***Bladder Infection***	☐ ***Pelvic Infections***	☐ ***Gonorrhea***	☐ ***Genital Warts***

Do you currently or have a history of Smoking	☐ ***Yes***	☐ ***NO***	***If yes how much? ____ How long? _____when did you quit?_____***
Do you exercise regularly?	☐ ***Yes***	☐ ***No***	***If yes how often? _____***
Do you drink Coffee/Tea/Cola?	☐ ***Yes***	☐ ***No***	***If yes how much/often_____***
Do you drink Alcohol?	☐ ***Yes***	☐ ***No***	***If yes, how much/often_____***
Have you ever used Marijuana?	☐ ***Yes***	☐ ***No***	***If yes, how much/often/when_____***
Have you ever used Cocaine?	☐ ***Yes***	☐ ***No***	***If yes, how much/often/when_____***
Have you ever used Heroin?	☐ ***Yes***	☐ ***No***	***If yes, how much/often/when_____***

Is there anything else regarding your health that the doctor needs to know?

_____