Patient Name:
Age: Date of birth:
Today's date: Who is your primary care doctor?:
What other doctors do you see?:

How were you referred to our clinic/doctor?:
What is the main problem or reason for seeing the doctor today?:

Do you request to have tests for sexually transmitted diseases (STDs):

Pap smear history: Last pap smear? Was it normal/abnormal?
Any previous abnormal pap?
Any previous treatment for abnormal pap?
if yes, please describe:

When did your last menstrual period start?
When was your last mammogram?
When was your last bone density test?

What pharmacy location do you prefer to have your prescriptions to(name/address)?:

Please list all current medications including the name, strength, how often you take it, etc.
Include PRESCRIPTIONS and Over-the-Counter medications.

Please list any medical problems YOU have or have had in the past.

Please list any surgeries YOU have had including the year the surgery was performed

Family History: please indicate if your family members are alive or deceased and list any medical problems for each.
(if you do not know family history details check here:_____)

	are they living?	what are/were their medical problems?
mother		
father		
other:		
other:		
other:		

other:		
other:		
other:		

Are you sexually active?

What is your usual method of pregnancy prevention/birth control?

Sexual preference (male,female,or both):

Do you drink alcohol?
what kind:
how much:

Tobacco
Please indicate below if you smoke now or in the past, and if so how much you smoke and what kind of tobacco you smoke, or if you quit when you last smoked.

Employment
Do you currently work or go to school:
Job title:
employer or school:

Spouse or partner's name:
How many children do you have?:
How many years of school have you finished?:
Your Preferred language:
Your Ethnicity:
Your Race:

Pregnancy History (please provide details requested below for ALL prior pregnancies including miscarriages or elective abortions)

DATE	WEEKS PREG	TYPE OF DELIVERY	Baby's Sex	Baby's weight	Complications during pregnancy or delivere	Epidural?
						YES/NO
						YES/NO
						YES/NO
						YES/NO
						YES/NO
						YES/NO
						YES/NO
						YES/NO
						YES/NO
						YES/NO
						YES/NO

Drug use information
Do you currently use drugs of any kind?:

Have you in the past used drugs of any kind?:

If you answered yes to either of the above please describe what drugs used and history of use, treatment, etc.:

Menstrual history

How many days apart do your period usually start?

How many days does your period usually last?

Is your period pattern REGULAR or IRREGULAR?

Is your period flow LIGHT, MODERATE, or HEAVY?

Which do you use (circle any that apply): PANTY LINER, THIN PAD, MAXI PAD, TAMPON, Other:

How often do you need to change the above item (for example every 2 hours versus twice a day)

Do you have painful cramping with your period? (CIRCLE one choice) NONE____Mild Pain____Moderate Pain____Severe Pain