Date: _____/_____/_____

Patient Name: ____________________________________ DOB: _________ AGE: ____

□ NO CHANGES TO MEDICAL HISTORY SINCE LAST VISIT

OB/GYN HISTORY

	NUMBER		NUMBER
Birth(s)		Abortion(s)	
Miscarriage(s)		Living Children	

SOCIAL HISTORY

Personal Habits	Current	Former	Never	Notes
Alcohol				# drinks per week: # drinks per day:
Drug Use				Type:
Tobacco				# packs per day: Age started: Age quit:
Exercise				Type of exercise:

GYN HISTORY

What is the first day of your last menstrual period? ____

Method of Contraception: □ Oral Contraceptives____

□ Condoms □ IUD □ Other______________________________________

Please check off any of the following that you are currently experiencing:

□Digestive Distress ____________________

□Pain with Intercourse

□Fatigue

□Leg Pain

□Loss of Urine with Stress

□Bladder Symptoms ____________________

□Abnormal weight loss/ weight gain

□Varicose or Inflamed Veins

□Irregular Periods ______________________

□Hot Flashes

□Premenstrual Tension

□Postmenopausal bleeding

□Pelvic Pain ___________________________

□Abnormal Vaginal Bleeding

□Vaginal Discharge

□Breast Changes_______________________

□Rectal Bleeding

□Other ________________________________

FAMILY HISTORY

Illness	Yes	No	Family Member	Age of Diagnosis
Breast Cancer				
Colon Cancer				
Ovarian Cancer				
Other Cancer ________________				

□ I AM ADOPTED

DRUG ALLERGIES

MEDICATION	REACTION

SINCE LAST VISIT:

NEW MEDICATIONS (DRUG NAME, DOSE) ____

____

____

SURGERIES (AND DATES): ____

____

MAMMOGRAM DATE: _____________________ BONE DENSITY SCAN DATE: ____________________________