



- A**
1. Marital Status: Single Married Long term Relationship Divorced Widowed
 2. Reason for this visit: _____
 3. Referring Physician: _____
 4. Occupation: _____
 5. Preferred phone number: _____ confidential voice mails OK: Yes No
 6. Partner: _____ None 7. Age of partner: _____
last first
 8. Occupation of partner: _____

- B MENSTRUAL HISTORY** (complete even if post-menopausal or no longer having periods)
7. Age at first period: _____ years.
 8. If your menstrual periods are regular; periods start every: _____ days
 9. If your menstrual periods are irregular; periods start every: _____ to _____ days (e.g., 12 to 60)
 10. Duration of bleeding: _____ days
 11. Does bleeding or spotting occur between periods? Yes No
 12. Does bleeding or spotting occur after intercourse? Yes No
 13. First day of last menstrual period _____
month day year
 14. Is pain associated with periods? Yes No Occasionally
 15. If yes to 14, is it: before menses? during menses? both?

- C PREGNANCY HISTORY (All pregnancies)** **Have never been pregnant**
16. OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

Year	Place of delivery or Abortion	Duration Preg.	Hrs. of Labor	Type of Delivery	Complications Mother and/or Infant	CHILD		
						Sex	Birth Weight	Present Health

- D BIRTH CONTROL HISTORY**
17. What birth control method(s) do you currently use? _____

- E SEXUAL HISTORY**
18. Do you have a sexual partner? No Yes (Male Female
19. Are there concerns about your sexual activity which you may want to discuss with your doctor? Yes No

MRN:
Patient Name:

(Patient Label)

F PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES

20. Check any that apply: or None

SURGERY	YEAR	SURGERY	YEAR
<input type="checkbox"/> D&C	<input type="text"/>	<input type="checkbox"/> ovarian surgery	<input type="text"/>
<input type="checkbox"/> hysteroscopy	<input type="text"/>	<input type="checkbox"/> L cyst(s) removed ovarian	<input type="text"/>
<input type="checkbox"/> infertility surgery	<input type="text"/>	<input type="checkbox"/> R cyst(s) removed ovarian	<input type="text"/>
<input type="checkbox"/> tuboplasty	<input type="text"/>	<input type="checkbox"/> L ovary removed	<input type="text"/>
<input type="checkbox"/> tubal ligation	<input type="text"/>	<input type="checkbox"/> R ovary removed	<input type="text"/>
<input type="checkbox"/> laparoscopy	<input type="text"/>	<input type="checkbox"/> vaginal or bladder repair	<input type="text"/>
<input type="checkbox"/> hysterectomy (vaginal)	<input type="text"/>	for prolapsed or incontinence	<input type="text"/>
<input type="checkbox"/> hysterectomy (abdominal)	<input type="text"/>	<input type="checkbox"/> cesarean section	<input type="text"/>
<input type="checkbox"/> myomectomy	<input type="text"/>	<input type="checkbox"/> other (specify)	<input type="text"/>

G PAST SURGICAL HISTORY (Not OB/GYN)

21. List all surgeries and their year or None

Surgeries	Year
_____	_____
_____	_____
_____	_____
_____	_____

H PAP SMEAR/MAMMOGRAM HISTORY

22. Date of last pap smear: _____

23. Have you had abnormal pap smears? No Yes

24. Have you had treatment for abnormal smears?
No Yes

If yes, what type(s) of treatment have you had?

}	cryotherapy	<input type="text"/>
	laser	
	cone biopsy	
	loop excision (LEEP)	

25. Date of last mammogram: _____
month year

26. Have you had an abnormal mammogram? No Yes

OTHER PAST GYNECOLOGICAL HISTORY

27. Check any that apply: None Venereal warts Herpes – genital Syphilis
 Pelvic inflammatory disease Endometriosis Chlamydia Gonorrhea
 Vaginal infections Other _____

MRN:
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I PAST MEDICAL HISTORY Check any that apply: or None

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes: | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Diet controlled | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pill controlled | (including hepatitis) | <input type="checkbox"/> HIV+ |
| <input type="checkbox"/> Insulin controlled | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease | |

J CURRENT MEDICATIONS (Include dose (amount) per day)

Medication	Dose	Frequency

K DO YOU CURRENTLY?:

28. Smoke No Yes _____ packs/day
29. Use alcohol No Yes _____ wine (glasses/day); _____ beer (bottles/day); _____ hard liquid (oz./day)
30. Use illicit drugs No Yes _____ type _____ amount
31. Exercise: Type: _____ How often _____

L DRUG ALLERGIES

32. No Yes List:

M FAMILY HISTORY

- | | | | |
|---|---|--|--------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Other |
| <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Endometrial Cancer | <input type="checkbox"/> Colon Cancer | _____ |
| | | | _____ |

If "yes" to any, please list affected relatives

 None of the above.

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N OTHER SYMPTOMS

Have you had recent?:

- | | | |
|---|---|--|
| <input type="checkbox"/> weight loss | <input type="checkbox"/> hair growth | <input type="checkbox"/> none of the above |
| <input type="checkbox"/> weight gain | <input type="checkbox"/> hair loss | <input type="checkbox"/> Other |
| <input type="checkbox"/> change in energy | <input type="checkbox"/> change in urinary function | _____ |
| <input type="checkbox"/> change in exercise tolerance | <input type="checkbox"/> hot flushes/flashing | _____ |
| | <input type="checkbox"/> breast discharge | |

O

Note: Fill out Section "O" only if you are pregnant or planning to be pregnant in the near future.

Have you or the baby's father or anyone in your families ever had any of the following:

- Down Syndrome (Mongolism)? If yes, who? _____
- Other Chromosomal abnormality? If yes, specify _____
- Neural tube defect (spina bifida, anencephaly)? If yes, who? _____
- Hemophilia or other coagulation abnormality? If yes, who? _____
- Muscular Dystrophy? If yes, who? _____
- Cystic Fibrosis? If yes, who? _____
- If you or the baby's biological father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?
 - Father Result _____
 - Mother Result _____
- If you or the baby's biological father are of African ancestry, have either of you been screened for Sickle cell trait?
 - Father Result _____
 - Mother Result _____
- If you or the baby's biological father are of Italian, Greek, or Mediterranean background, have either of you been tested for B-thalassemia?
 - Father Result _____
 - Mother Result _____
- If you or the baby's biological father are of Philippine or Southeast Asian ancestry, have either of you been tested for A-thalassemia?
 - Father Result _____
 - Mother Result _____

PATIENT SIGNATURE

DATE

TIME

PHYSICIAN SIGNATURE

DATE

TIME