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Date: ____________________

Name: ____________________ **D.O.B:** __________ **Age:** __________

Allergies and reaction: ____________________

Current medications/Vitamins/Supplements (with dose): ____________________

____

First day of Last Period: __________ **Do you Perform Self Breast Exams?** Yes, No, Sometimes

Current Method of Birth Control: ____________________

Previous Methods of Birth Control: ____________________

Age at first menses: ______ **Days between Menses:** __________ **Regular?:** Yes or No

Duration of menses: __________ **Problems with Menses?** ____________________

Year or age at Menopause: __________ **History of HRT?** ____________________

Date of Last pap: __________ **Location:** ____________________

Date of Last mammo: __________ **Location:** ____________________

Date of Last Bone Density: __________ **Location:** ____________________

Age at First Intercourse: ______ **# Partners in a Lifetime:** ______ **Preference?:** Men, Women, Both

History of Sexually Transmitted Diseases: ____________________

Pregnancies: **Total:** ______ Vaginal: ______ C-Section: ______ Abortion: ______

Miscarriage: ______ Ectopic: ______ Premature: ______ VBAC: ______ Living: ______

Pregnancy Complications: ____________________

List pregnancies in order of occurrence with outcome: (Please Complete only if *Under* Age 50)

____

____

____

History of Childhood Illness (i.e. Chickenpox, mumps, measles, asthma, etc): ____________________

History of Serious Accidents or Injury: ____________________

Do You Have a History of Abnormal Paps? ____________________

History of Gynecological Procedures (Colposcopy, LEEP, conization, etc.): ____________________

____

Past Medical Diagnosis' (i.e. Cancer, heart issue, diabetes, thyroid disorder, Bleeding disorder, etc..)

____

____

Surgical History (including wisdom teeth and tonsillectomy): ____________________

____

Any Anesthesia Complications: ____________________

Family Medical history (i.e. cancer, heart issue, diabetes, thyroid disease, kidney disease, GI disorder, bleeding disorder)

Mother: Living: Y or N ____________________

Father: Living: Y or N ____________________

Pat. G.mother Living: Y or N ____________________

Pat. G.father Living: Y or N ____________________

Mat. G.mother Living: Y or N ____________________

Mat. G.father Living: Y or N ____________________

Siblings: ____________________

Marital Status: __________ **Highest Level of Education:** ____________________

Live With?: __________ **Current Employment:** ____________________

Diet (circle one) Excellent , Good, Fair, Poor **Pets?:** ______ **History of Drug Use:** ______

Caffeine #/Day: Soda: ______ Coffee: ______ Tea: ______ Energy Drinks: ______

Are you/Have You Ever Been a Smoker/Vape? ______ Packs/Day ______ **Years Smoked/Vaped** ______

Alcohol? Never Daily Weekly Rarely