Last Menstrual Period Date ____

Briefly state your reason for visit____

ALLERGIES/REACTIONS Please list any drug, food or environmental allergies and your reaction	

Please list **any** family medical history (heart disease, diabetes, cancer,etc.)

Disease	Family Member	Disease	Family Member

PAST MEDICAL	
Date of Last Pap:	Abnormal (Circle) Yes No
History of abnormal pap? (Circle) Yes No	If yes, list treatment
Date of Last Mammo:	Abnormal (Circle) Yes No
History of abnormal mamo? (Circle) Yes No	If yes, list treatment
Date of Last Bone Density:	Abnormal (Circle) Yes No

GYN HISTORY	
Age period began:	Painful Periods (Circle) Yes No
Flow/Duration of period:	# of days **between** periods:
Are you sexually active? (Circle) Yes No	Painful Intercourse (Circle) Yes No
Primary Method of Birth Control	
Age Menopause began:	Blood Transfusion (Circle) Yes No

List Past GYN Problems	List Other Medical Problems	List Surgeries

Pregnancy History

# of Pregnancies: _______ # of Abortion/Miscarriages: ________ # of Living Children:_________

Number of:	List Dates	Complications?
Vaginal Deliveries		
C-Sections		

Tobacco Use? (Circle) Yes No	Alcohol Use? (Circle) Yes No
Amount:	Amount:
Drug Use? (Circle) Yes No	Caffeine Use? (Circle) Yes No
Amount:	Amount:

MEDICATIONS: Please list any medications the patient is currently taking			
Medication Name	Strength/Dose	Medication Name	Strength/Dose