

**FAMILY HISTORY** (parents, grandparents, siblings, parents' siblings)

Is patient adopted? NO \_\_\_\_\_ YES \_\_\_\_\_ If yes, complete only if known for biological family.

	NO	YES	Whom		NO	YES	Whom
High Cholesterol	_____	_____	_____	Substance Abuse	_____	_____	_____
Diabetes	_____	_____	_____	High Blood Pressure	_____	_____	_____
Cancer (type)	_____	_____	_____	Stroke	_____	_____	_____
Heart Disease (age)	_____	_____	_____	Blood Clots	_____	_____	_____
Osteoporosis	_____	_____	_____	Thyroid Disorder	_____	_____	_____
Other _____				Other _____			

**PERSONAL MEDICAL HISTORY**

	NO	YES			NO	YES
Acne	_____	_____	_____	Thyroid Disorder	_____	_____
Headaches	_____	_____	_____	Hirsutism (excess hair)	_____	_____
Migraines	_____	_____	_____	Diabetes	_____	_____
Blurred or double vision	_____	_____	_____	Liver-hepatitis, recent jaundice	_____	_____
Contact lenses/glasses	_____	_____	_____	Lung disease	_____	_____
Dizziness/ fainting	_____	_____	_____	Asthma	_____	_____
Tensions, emotional problems	_____	_____	_____	Smoking (amount)	_____	_____
Mental depression	_____	_____	_____	Weight/ nutritional prob.	_____	_____
Epilepsy	_____	_____	_____	Breast surgery/ prob.	_____	_____
Heart abnormality (murmur, irreg. rate/rhythm)	_____	_____	_____	Cancer (type)	_____	_____
Rheumatic fever	_____	_____	_____	Kidney disease	_____	_____
Hypertension	_____	_____	_____	Kidney infection	_____	_____
Blood clots (leg, lung, brain)	_____	_____	_____	Bladder infection	_____	# in past year _____
Varicose veins	_____	_____	_____	X-rays of head or neck during infancy	_____	_____
Blood disease	_____	_____	_____	Gall bladder disease	_____	_____
Anemia	_____	_____	_____	DES exposure	_____	_____
Bleeding Disorder	_____	_____	_____	Mono in past 6 months	_____	_____
High cholest./ triglycer.	_____	_____	_____	List any past surgeries or hospitalizations	_____	_____
Sickle cell anemia (dis.)	_____	_____	_____	_____		
Blood transfusion	_____	_____	_____	_____		
Sickle cell trait	_____	_____	_____	_____		
Rubella (dis. or immuniz.)	_____	_____	_____	_____		
Other _____				_____		

**MENSTRUAL HISTORY**

Age at onset of menstruation \_\_\_\_\_ Date last period started \_\_\_\_\_  
 Was it a normal period?  Yes  No Cycles are:  Reg.  Irreg.  
 They occur every \_\_\_\_\_ days Flow:  heavy  med.  light  
 Lasts \_\_\_\_\_ days. On the heaviest day of your period, how many pads or tampons do you normally use? \_\_\_\_\_ Do you have pain with your period?  
 No  mild  moderate  severe Medication used for cramps: \_\_\_\_\_  
 Does it relieve the cramps?  Yes  No

**PREGNANCY HISTORY**

Have you ever been pregnant?  No  Yes  
 Number of Pregnancies: \_\_\_\_\_ Age 1st preg. \_\_\_\_\_  
 Possible Pregnancy Now:  No  Yes  Maybe  

#	Dates	Explain any problems
Live Births	_____	_____
Living Children	_____	_____
Ectopic Pregnancy	_____	_____
Miscarriages	_____	_____
Stillbirths	_____	_____
Elective Abortions	_____	_____

**GYNECOLOGICAL HISTORY**

Are you sexually active?  No  Yes Age at first intercourse \_\_\_\_\_  
 Number of lifetime sexual partners? \_\_\_\_\_ # in last 6 mos. \_\_\_\_\_  
 Have you been diagnosed with any of the following?  

	NO	YES
Endometriosis	_____	_____
Uterine tumors	_____	_____
Infections of tubes uterus, ovaries	_____	_____
Vaginal infections	_____	_____
HPV(Warts)	_____	_____
Herpes	_____	_____
Chlamydia	_____	_____
Gonorrhea, syphilis	_____	_____
Postcoital bleeding	_____	_____
Bleeding between periods	_____	_____
Pain during sex	_____	_____
Abnormal paps	_____	_____
Breast abnormality	_____	_____
Last pelvic exam _____		Last pap test _____

**PURPOSE OF VISIT:** Pap smear \_\_\_\_\_ Birth Control \_\_\_\_\_ Problem \_\_\_\_\_

I certify that to the best of my knowledge the above information is complete and correct.

PATIENT'S SIGNATURE \_\_\_\_\_ Interviewer's Signature \_\_\_\_\_

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
last first middle

ADDRESS \_\_\_\_\_ UID \_\_\_\_\_

TELEPHONE NO. \_\_\_\_\_ AGE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

ALLERGIES:  NO  YES SPECIFY \_\_\_\_\_

List medications taken regularly (including prescription meds, vitamins, herbal supplements, nutritional supplements, etc.) \_\_\_\_\_

**SOCIAL & CURRENT HEALTH**

Does your diet provide a variety of milk products (or calcium supplement),  
vegetables/fruits, breads/cereals, and protein?  Yes  No

Does concern about your weight or food interfere with your studies/work?  Yes  No

How often do you exercise? \_\_\_\_\_ days per week \_\_\_\_\_ minutes per day

Do you use drugs?  Yes, type used \_\_\_\_\_  No

Do you smoke?  Yes, \_\_\_\_\_ cigarettes/day  No

Do you drink alcohol?  Yes, \_\_\_\_\_ drinks/week  No

Do you regularly use seatbelts?  Yes  No

Do you regularly use a bicycle/motorcycle helmet?  Yes  No  Not applicable

How do you feel your general health is now? \_\_\_\_\_

Have you had any recent illness/surgery in the last 6 months? If so, please explain. \_\_\_\_\_

Do you have any problems or issues you would like to discuss? \_\_\_\_\_

**PERSONAL HISTORY**

Do you do a SELF breast exam?  Yes  No Have you been taught how?  Yes  No

Have you had a pelvic exam or pap smear before?  Yes, Date \_\_\_\_\_  No

Are you currently in a sexual relationship?  Yes, How long? \_\_\_\_\_  No

Have you or your partner had other sexual partners in the past six months?  Yes  No

Are your past or present sexual partners:  Male  Female  Both

Have you ever had a painful or frightening sexual experience?  Yes  No

Do you have concerns about a past or current experience with physical or  
emotional violence in a dating or family relationship?  Yes  No

Have you ever been forced to have sex?  Yes  No

**CONTRACEPTIVE HISTORY**

If applicable, current method of birth control \_\_\_\_\_  Not applicable

Where did you get your current method of birth control? \_\_\_\_\_

What methods of birth control have you used in the past? \_\_\_\_\_

Did you have any problems with previous methods of birth control?  No  Yes, please explain \_\_\_\_\_