



# PATIENT INFORMATION

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

ADDRESS \_\_\_\_\_ UIN \_\_\_\_\_

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

Have you had the (HPV) Gardasil Vaccine series?  Yes  No

Please list the dates of your vaccine, if you know. 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

## 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 \_\_\_\_\_



# GYNECOLOGICAL HISTORY

## 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	_____
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 \_\_\_\_\_