Patient Name:_____ Age:_____ Date of Birth:_____ Today's Date:_____

Primary Care Physician:_____ Who referred you to us:_____

What is the purpose for your appointment today?	Comprehensive/ Annual Exam	Contraception	Difficulty getting Pregnant	Breast Problems	Pelvic organ prolapse	Premarital Exam
	Menopausal Symptoms	Menstrual Problems	Pelvic Pain	Emotional Problems	Urinary Incontinence	Other:

PLEASE FILL OUT COMPLETELY / CIRCLE ALL THAT APPLY (per column)

Family History (enter information below)	PERSONAL Medical History	PERSONAL Surgical History	PERSONAL Social History
Blood Clots/ DVT:	Abnormal Pap Smear	Abdominoplasty	Marital Status:
	Anesthesia Reaction	Appendectomy	
Breast Cancer:	Anemia	Bladder Surgery	Occupation:
	Anxiety / Depression	Breast Augmentation	
Colon Cancer:	Asthma	Breast Surgery	Religion:
	Bowel Problem / IBS	C-Section	
Diabetes:	Cancer	Ectopic Pregnancy	Tobacco Use:
	Clotting Disorder	Endometrial Ablation	
Genetic Conditions:	Diabetes I or II	Essure	Alcohol Use:
	DVT / Blood Clot / PE	Fibroid Removal	
Heart Disease:	Ectopic Pregnancy	Gallbladder Removal	Illicit Drug Use:
	Fibroid Uterus	Hand Surgery	
High Blood Pressure:	Endometriosis	Hernia Repair	History of Addiction:
	Epilepsy / Seizures	Hysterectomy	
Ovarian Cancer:	Heart Disease	Hysteroscopy	Domestic Abuse
	Hepatitis / Liver Disease	Knee Surgery	
Stroke:	High Blood Pressure	Laparoscopy	Sexual Abuse
	Kidney Disease	Ovarian Cyst Surgery	
Thyroid Disease:	Kidney Stones	1 Ovary removed	History of STD Specify:
	Menstrual Problems	Both Ovaries	
Uterine Cancer:	Migraine Headaches	Shoulder Surgery	
	Osteoporosis	Sling	
Unknown/Adopted	Ovarian Cyst	Tonsillectomy	
	PCOS	Tubal Ligation	
Other:	Thyroid Disorder	Other:	
	Other:		

LIST ALL Current Medications

Drug	*Dose*

Allergies to Medications

Drug	*Reaction*
Penicillins	
Sulfas	
Cephalosporins	
Erythromycin	
Percocet	
Morphine	
Codeine	
Norco / Lortab	
Iodine	
LATEX	
Other:	

Reproductive History	Total # of Pregnancies:	Full Term:	Preterm:	Living Children:	Adopted:	Ectopic:
	Miscarriages:	Abortions:	How many vaginal births:		How many C -Sections:	

SEXUAL HISTORY						
Are you sexually active?	Yes	Never	Previously, Not Now			
What do you use for contraception?	Nothing	Pills	Mirena/Kyleena/IUD	Paragard IUD	Vasectomy	Condoms
	Nuva Ring	Depo Provera	Nexplanon	Tubal Ligation	Other:	
Do you have any of the following problems with intercourse?	No	Pain	Spotting	Dryness	Other:	

CURRENT MENSTRUATION: *** If you are menopausal, PLEASE skip this section					
Please list the first date of your last menstrual cycle:	Date:_____				
What best describes the regularity of your menstrual cycles?	Regular	Irregular	Infrequent	Infrequent due to: (circle one) IUD BC Pills Nexplanon	
How often do your menstrual cycle occur? Every?	<23 Days	24-35 Days	36-90 Days	1-3 Per Year	Rarely
How would you best describe your menstrual flow on most days of your cycle?	Light	Normal	Moderate	Heavy	Heavy w/ clots
How many days do you bleed during an average menstrual cycle?	<2 Days	2-4 Days	4-7 Days	7-10 Days	>10 Days

Do you bleed or spot between cycles?	No	Occasionally	Frequently		
How would you best describe your cramps / pain during your menstrual cycles?	None	Mild	Moderate	Severe	Debilitating
Do you experience any premenstrual syndrome (PMS) Symptoms?	No	Minimal	Moderate	Severe	Debilitating

MENOPAUSAL: ***If you are still having menstrual cycles PLEASE skip this section					
How many years since your last menstrual cycle?	1	2	3-5	6-10	>10
How did your menopause occur?	Naturally	Secondary to Hysterectomy		Secondary to Hysterectomy removal of ovary / ovaries	
Do you have POSTmenopausal vaginal bleeding?	No	Occasionally	Frequently	Only with Intercourse	
Do you experience any menopausal symptoms? (Circle all that apply)	No	Hot Flashes	Mood Swings	Sleep Disturbances	Vaginal dryness
Are you currently using any hormone therapy?	No	Yes			

PAP SMEAR HISTORY:						
How many years was your last Pap Smear?	Less than 1 yr	1-2	3-4	5-10	>10	Never
Have you ever had an abnormal Pap Smear	No	Yes				
If YES..How many years ago was your last Abnormal Pap Smear?	Less than 1 yr	1-2	3-4	5-10	>10	
Circle any procedures you have ever had done for abnormal paps	None	Colposcopy	Biopsies	Cryo/Freezing	LEEP	Cone Biopsy

PERIODIC SCREENINGS						
How many years ago was your last mammogram?	Never	Less than 1 yr	1-2	3-4	5-10	>10
Have you ever had an abnormal mammogram?	No	Yes	**Every 1-2 Years after age 40. Every year after age 50**			
Do you have any of the following symptoms? (circle all that apply)	No	Breast Mass/Lump	Breast Pain	Nipple Discharge	Skin Changes	
How many years ago was your last Colonoscopy?	Never	1-5	6-10	>10	Every 10 years after age 50	
Have you ever had an abnormal Colonoscopy?	No	Yes				

American College of Obstetrics and Gynecology guidelines state:
All sexually active adolescents and young women up to the age of 25 years should undergo annual testing for Chlamydia and Gonorrhea.
This testing is also available for women of any age.

Would you like to have testing for ***Sexually Transmitted Infections?*** **YES** **NO**

Is there anything else you would like to discuss today?