Name: _____ DOB: _____ Today's Date: _____ MR#: _____ Page 1

Please fill out your Health History **fully**. YES!—We understand we ask for detailed personal information—having a thorough history helps us provide you with the BEST possible care!

GYN HISTORY

Last Menstrual Period (date): _____

Menstrual History: Age at first period _____

How many days apart are your periods (from the start of one period to the next)? _____ to _____days apart

How many days do you bleed? _____ days

How is the flow? ☐ Light ☐ Medium ☐ Heavy

PMS Symptoms: ☐ No ☐ Yes:_____

Menstrual cramps: ☐ No ☐ Yes:_____

Pain with intercourse: ☐ No ☐ Yes:_____

Birth Control Method:

☐ Oral Contraceptive Pills (name):_____

☐ NuvaRing ☐ OrthoEvra (patch)

☐ Depo-Provera (injection every 3 months)

☐ Nexplanon/Implanon (3 year, rod implant)

☐ Mirena IUD (5 year, hormonal)

☐ Copper T IUD (10 year, nonhormonal)

☐ Condoms

☐ Diaphragm ☐ Cervical Cap

☐ Natural Family Planning (type): _____

☐ Abstinence

☐ Tubal Ligation ☐ Vasectomy

☐ None, Desiring Conception

☐ None, OK with pregnancy

☐ None, NOT Desiring pregnancy

☐ None: ☐ Menopause ☐ Hysterectomy

Breast History:

Do you perform Self Breast Exams? ☐ Yes ☐ No

Breast problems:_____

Last **Mammogram** (date):_____

Menopause History:

Age at menopause: _____

Have you used Hormone Replacement?

☐ No ☐ Yes: (Types)_____

Mother's menopause age:_____

PAP History:

Last **PAP smear** (date):_____

Last **HPV screen** (date):_____

History of abnormal PAPs?: ☐ Never

☐ Yes (Mo/Yr):_____

Was a biopsy done? ☐ Yes ☐ No ☐ Unknown

Any treatment? ☐None

☐ Cryotherapy (Freeze the cervix)

☐ Cone biopsy (surgery in OR)

☐ LEEP ☐ LASER

Sexual History:

Have you had sexual relations in the **last year**?

☐ Yes ☐ No

Orientation: ☐ Heterosexual ☐ Bisexual

☐ Homosexual ☐ Other

How long have you been sexually active with your **current** partner? _____

Have you or your partner been sexually active with **anyone else** during this time? ☐ No ☐ Yes

In the **last year**, how many partners have you had?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5-10 ☐ >10

How many partners have you had in your **lifetime**?

☐ 0 ☐ 1 ☐ 2-5 ☐ 6-10 ☐ >10

Do you **ALWAYS** use condoms? ☐ Yes ☐ No

STD History:

Have you ever had any of the following?:

☐ Trichomonas ☐Hepatitis B ☐Hepatitis C

☐ Chlamydia ☐ Syphilis ☐HIV/AIDS

☐ Gonorrhea ☐Herpes: ☐ Oral ☐ Genital

☐ HPV ☐ Molluscum contagiosum

Have you been tested for STDs since the start of your most recent relationship? ☐ Yes ☐ No

Last STD testing (Mo/Yr) :_____

☐ Vaginal ☐ Blood ☐ Urine

Do you have any tattoos? ☐ None ☐ Yes

Have you ever been tested for Hepatitis C? ☐ No ☐ Yes

Name: _____ DOB: _____ Today's Date: _____ MR#: _____

Prior Infertility Treatment: ☐ Clomid/Femara: # of cycles? _____ ☐ IUI (Intrauterine Insemination): _____

☐ FSH injection: _____ ☐ Ovidrel (hCG) injection: _____ ☐ IVF: _____

Notes: _____

PREVIOUS PREGNANCIES

PLEASE LIST ALL PREGNANCIES INCLUDING MISCARRIAGES, ABORTIONS OR OTHER FAILED PREGNANCIES

	DATE	LENGTH OF PREG (<37w?)	TYPE OF DELIVERY Vag	TYPE OF DELIVERY CSx	TREATMENTS TO CONCEIVE	# OF MONTHS IT TOOK TO CONCEIVE	BABY'S GENDER	BABY'S WEIGHT ≥9#?	CHILD'S NAME	PROBLEMS WITH MOM AND/OR BABY
1										
2										
3										
4										
5										
6										

ALLERGIES ☐ No Known Drug Allergies

Medication	Allergic Reaction		Medication	Allergic Reaction

MEDICATIONS ☐ None (please include prescription, vitamin, herbal products, and over-the-counter meds)

Name of Medication	Dose (mg/pill)	How many pills in: Morning?	How many pills in: Evening?	Prescribing Doctor	Reason for taking Medication?
Calcium ☐ No ☐ Yes					
Vitamin D ☐ No ☐ Yes					
Multivitamin ☐ No ☐ Yes					

Please include medical problems and history of hospitalizations:

YOUR MEDICAL HISTORY Do **YOU** have a history of:	YES?	Age at diagnosis	Managing Physician	Comments
Birth Defect	☐			
Asthma	☐			
Breast Cancer	☐			
Breast Problems	☐			
Twins or Multiple Births	☐			
Pelvic Organ Cancer (type?)	☐			
Colon Cancer	☐			
Other Cancers (type?)	☐			
Diabetes Type 1	☐			
Diabetes Type 2	☐			
Heart Attack	☐			
Stroke	☐			
High Blood Pressure	☐			
Lung Problems	☐			
Kidney Disease	☐			
GastroIntestinal Problems	☐			
Blood Transfusions	☐			
Osteoporosis	☐			
Thyroid Disease	☐			
Depression	☐			
Anxiety	☐			
Anemia/Bleeding /bruising	☐			
Blood clots in Lung or Leg	☐			
Clotting Disorder (type?)	☐			
Trauma	☐			
Other:	☐			
Other:	☐			
Other:	☐			

Last **Colonoscopy** (date):_____ ☐ Never Last **DEXA** (bone density) scan (date):_____ ☐ Never

VACCINATION HISTORY	Date given (year)	**VACCINATION HISTORY**	Date given (year)
Pneumovax (Pneumonia)		Zostavax (Shingles)	
Influenza (Flu)		Gardasil/Cervarix (HPV)	

PAST SURGERIES ☐ None		Reason for Surgery	Open procedure, Laparoscopic, or Robotic? Complications during or after surgery?
Year	Name or Type of Surgery		

SOCIAL HISTORY

SUBSTANCE USE			Year Quit
Tobacco—Smoking	☐ Never	_____ packs/day x _____ years	
Tobacco—Chewing	☐ Never	_____ cans/day x _____ years	
Alcohol	☐ Never	_____ drinks/_____ ☐ Beer ☐ Wine ☐ Liquor	
Illicit drugs	☐ Never	Which drugs?	

Marital status: ☐ Single ☐ Married ☐ In a relationship ☐ Live with partner
☐ Separated ☐ Divorced ☐ Widowed

Education Level: _____ Degree:_____

Employer: _____ Job Title/Description: _____ ☐ Full-time ☐ Part-time

Do you Exercise regularly? ☐ No ☐ Yes

Type of Exercise: ☐ Aerobic:_____ How many times **weekly**?___ How many **minutes** each time? ___
☐ Weight-training:_____ How many times **weekly**?___ How many **minutes** each time? ___

Do you use the following? ☐ Chiropractor ☐ Massage ☐ Acupuncture

Do you use the following regularly? ☐ Seatbelts ☐ Sunscreen ☐ Smoke detectors ☐ Carbon Monoxide detectors

Do you feel safe at home? ☐ Yes ☐ No

Has anyone (including your partner) tried to hurt you in the past? ☐ No ☐ Yes

Religious preference: ☐ No ☐ Yes _____

FAMILY HISTORY Place an X in the column of the family member(s) who has(have) the given condition.	YES?	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle	COMMENTS
Birth Defect	☐													
Asthma	☐													
Breast Cancer	☐													AGE at diagnosis:
Breast Problems	☐													
Twins or Multiple Births	☐													
Pelvic Organ Cancer (type?)	☐													
Colon Cancer	☐													AGE at diagnosis:
Other Cancers (type?)	☐													
Diabetes Type 1	☐													
Diabetes Type 2	☐													
Heart Attack	☐													AGE at diagnosis:
Stroke	☐													
High Blood Pressure	☐													
Lung Problems	☐													
Kidney Disease	☐													
GastroIntestinal Problems	☐													
Blood Transfusions	☐													
Osteoporosis	☐													
Thyroid Disease	☐													
Depression	☐													
Anxiety	☐													
Anemia/Bleeding/bruising	☐													
Blood clots in Lung or Leg	☐													
Clotting Disorder (type?)	☐													
Other:	☐													
Other:	☐													

Are you **CURRENTLY** experiencing any of the following?

General
- ☐ Chills
- ☐ Fever
- ☐ Forgetfulness
- ☐ Loss of Sleep
- ☐ Weight loss
- ☐ Weight gain

Skin
- ☐ Change in mole appearance
- ☐ Sore that won't heal
- ☐ Rash
- ☐ Abnormal hair growth
- ☐ Acne

Head, Eyes, Ears, Nose, Throat
- ☐ Headaches
- ☐ Dizziness/Passing Out
- ☐ Visual changes
- ☐ Loss of hearing
- ☐ Difficulty swallowing
- ☐ Hoarseness

Lungs/Heart
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Irregular/Rapid heart beat
- ☐ Leg pain/swelling/poor circulation
- ☐ Varicose veins

Breasts
- ☐ Pain
- ☐ Lumps
- ☐ Nipple Discharge: clear, bloody, or milky?_____

Abdomen
- ☐ Appetite poor/excessive
- ☐ Bloating/Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Bloody stool/rectal bleeding

Kidney/Bladder
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Difficulty with urinating
- ☐ Leaking urine
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Kidney stones

Gynecologic
- ☐ Vaginal discharge
- ☐ Vaginal itching
- ☐ Irregular bleeding
- ☐ Pelvic pain

Muscles/Joints/Bone
- ☐ Joint pain/stiffness
- ☐ Joint swelling
- ☐ Muscle cramps:_____
- ☐ Muscle weakness:_____

Neurological
- ☐ Numbness:_____
- ☐ Seizure/Convulsions
- ☐ Migraine Headaches

Endocrine
- ☐ Hair loss
- ☐ Hot flashes/sweats
- ☐ Feeling cold
- ☐ Decreased sex drive/libido

Hematologic
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Tender lymph nodes
- ☐ Anemia

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Panic attacks

Notes:

_____

_____

_____

_____

Patient's Signature: _____ Date: _____

I confirm that I have reviewed the information above.

Provider's Signature: _____ Date: _____