NAME: ____ Reviewed_________ Pt initials________MD/NP__________

Date: ________/________/________ Reviewed_________ Pt initials________MD/NP__________

Referred by: _____________________________________ Reviewed_________ Pt initials________MD/NP__________

Number of pregnancies: ________ Number of children: ________ Date of birth________/________/________

GYN HISTORY	*YES*	*NO*	
Are your periods regular, once a month?			Are you in a single partner relationship? yes no
Do you have cramps with your periods?			Current contraception? none
Any bleeding between your periods?			condoms pills depo provera shot
Have you ever been sexually active?			patch IUD vaginal ring diaphragm
Are you currently sexually active?			tubal ligation vasectomy rhythm method
If so, is partner male female			Any history of : ovarian cyst
			fibroids
Duration _________months or __________years			breast lump/breast disease

Please check if you have ever been treated for any of the following infections:		*YES*	*NO*
Vaginal bacterial infection/BV/Vaginosis	Have you ***ever*** had an abnormal pap smear?		
Trichomonas	When?______________*(w/in 3 years=HR)*		
Genital Warts	Has it been more than 7 years since your last pap smear?		
Gonorrhea	Did you begin sexual activity before you were 16 years old?		
Chlamydia	Have you had more than 5 sexual partners in your lifetime?		
Syphilis	Have you ever been diagnosed with HIV?		
Herpes	Did your mother take the drug DES while pregnant with you?		
	In the event of an emergency, will you accept a blood transfusion?		

MEDICAL PROBLEMS	*YES*	*NO*		***MEDICAL PROBLEMS***	*YES*	*NO*
High blood pressure				Blood clots in veins/arteries		
Diabetes				Ulcers		
Asthma/chronic lung disease				Depression/anxiety		
Kidney infection/stones				Anemia		
Heart trouble/murmur				Blood transfusions		
Cancer			type_________	Seizures/convulsions/epilepsy		
Thyroid disease				Bowel problems		
Allergies				Glaucoma		
Stroke				Hepatitis/jaundice		
Migraines				Other____		

OPERATIONS	*YES*	*NO*	*DATE*		*YES*	*NO*	*DATE*
C-section				Gall bladder removed			
Hysterectomy				Breast biopsy			
Ovarian surgery				Other surgery/hospitalization:			
Tubal ligation							
Appendectomy				____			

FAMILY HISTORY	*YES*	*NO*	*WHO?*		*YES*	*NO*	*WHO?*
Breast cancer				Diabetes			
Ovarian cancer				Heart attack/stroke before age 50			
Uterine cancer				Osteoporosis			
Colon cancer				Blood clot requiring blood thinners			
High blood pressure				Other:____			

MEDICATIONS: none	***ALLERGIES:*** none

SOCIAL HISTORY	*YES*	*NO*		*YES*	*NO*
Do you smoke?			Do you exercise regularly?		
Do you drink alcohol at all?			Do you eat a diet high in fat/sugar?		
Avg. # drinks/day_______			Do you wear a seat belt?		
Do you use any recreational drugs?			Do you feel safe in your home/relationship? Yes No		

REVIEW OF SYSTEMS: *Please check if any of the following apply:*

	Today's Date:	*Date:*	*Date:*	*Date:*
1. CONSTITUTIONAL	Weight loss/gain (unexpl.) Headaches Fever Fatigue			
2. EYES	Spots before eyes Vision changes			
3. ENT/MOUTH	Ear problems Ringing in ears Sinus problems			
4. CARDIOVASCULAR	Chest pain Heart racing/skipping beats			
5. RESPIRATORY	Wheezing Shortness of breath			
6. GASTROINTESTINAL	Diarrhea or constipation Blood in stool Nausea/vomiting			
7. GENITOURINARY	Pain with urination Frequency/urgency of urination Leaking urine Heavy periods Irregular periods Bleeding between periods Pelvic pain Pain with intercourse Vaginal itching/burning Abnormal discharge			
8. MUSCULOSKELETAL	Muscle weakness Muscle/joint pain			
9. SKIN/BREAST	Pain in breast Lump in breast Nipple discharge Rash Ulcers/sores			
10. NEUROLOGICAL	Dizziness Numbness in arms/legs			
11. PSYCHIATRIC	Depression or anxiety			
12. ENDOCRINE	Heat/cold intolerance Abnormal thirst Hot flashes			
13. HEMATOLOGIC/ LYMPH	Frequent bruises Cuts that do not stop bleeding Enlarged lymph nodes/glands			
14. ALLERG/IMMUNOL.	Allergies (food/pollen/etc)			

Last period:	Never	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
Last pap smear:	Never	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
Last mammogram:	Never	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
Last bone density test:	Never	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
Last colonoscopy:	Never	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____

Patient signature ____ Date _______________

Physician/NP signature ____________________________________ Date _______________

Reviewed: Date ________ Pt initials _______ MD/NP initials________

Reviewed: Date ________ Pt initials _______ MD/NP initials________

Reviewed: Date ________ Pt initials _______ MD/NP initials________