

<b>Name:</b>		<b>Date of Birth:</b>	
<b>MEDICAL HISTORY</b>		<b>YOU</b>	<b>FAMILY</b>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney/Bladder/UTI	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual/Domestic Abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	
Pulmonary Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Female/Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Gall Bladder	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach or Bowel	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia/Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
AIDS (HIV)	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	
<b>SUBSTANCE USE</b>		<b>Yes</b>	<b>No</b>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	
Recreational Drugs	<input type="checkbox"/>	<input type="checkbox"/>	
Other Health Supplements	<input type="checkbox"/>	<input type="checkbox"/>	
<b>SEXUAL HISTORY</b>		<b>Yes</b>	<b>No</b>
Have you ever been sexually active?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Sexual Concerns:</b>			
Pain with intercourse	<input type="checkbox"/>	<input type="checkbox"/>	
No Sex Drive	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding with intercourse	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a new partner in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Have you ever had an STD?</b>		<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	
Trichomonas	<input type="checkbox"/>	<input type="checkbox"/>	
HPV	<input type="checkbox"/>	<input type="checkbox"/>	
Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	
HIV	<input type="checkbox"/>	<input type="checkbox"/>	
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	
<b>LIFESTYLE</b>		<b>Yes</b>	<b>No</b>
Have you ever had a PAP test?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had an abnormal PAP?	<input type="checkbox"/>	<input type="checkbox"/>	
Was your abnormal PAP treated with any of the following methods:			
Cryosurgery (freezing the cervix)	<input type="checkbox"/>	<input type="checkbox"/>	
Colposcopy (biopsy of the cervix)	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had a mammogram?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you do monthly self breast exams?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you exercise on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>VACCINATIONS</b>		<b>Yes</b>	<b>No</b>
Have you ever been vaccinated for:			
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	
		<b>Yes</b>	<b>No</b>
Have you had a Tetanus shot within the last 10 years?		<input type="checkbox"/>	<input type="checkbox"/>
<b>MENSTRUAL HISTORY</b>			
Post Menopausal or had hysterectomy:		<input type="checkbox"/>	<input type="checkbox"/>
First day of last period:		___/___/___	
Age of first menses:		_____	
Interval (days between periods):		Days:	_____
Length of period:		Days:	_____
Spotting:		<input type="checkbox"/>	<input type="checkbox"/>
<b>Abnormalities:</b>			
None		<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding		<input type="checkbox"/>	<input type="checkbox"/>
Pain		<input type="checkbox"/>	<input type="checkbox"/>
Unusual Discharge		<input type="checkbox"/>	<input type="checkbox"/>
<b>BIRTH CONTROL</b>		<b>Yes</b>	<b>No</b>
<b>Current Contraceptive Method:</b>			
None		<input type="checkbox"/>	<input type="checkbox"/>
Oral Contraceptive Pill		<input type="checkbox"/>	<input type="checkbox"/>
Depo Provera		<input type="checkbox"/>	<input type="checkbox"/>
Condoms		<input type="checkbox"/>	<input type="checkbox"/>
Tubal Ligation		<input type="checkbox"/>	<input type="checkbox"/>
Hysterectomy		<input type="checkbox"/>	<input type="checkbox"/>
Post Menopausal		<input type="checkbox"/>	<input type="checkbox"/>
Other: _____			
How long used: _____			
Satisfied with current method?		<input type="checkbox"/>	<input type="checkbox"/>
Planning pregnancy?		<input type="checkbox"/>	<input type="checkbox"/>
<b>SURGICAL HISTORY</b>		<b>Complications:</b>	
		<b>Yes</b>	<b>No</b>
Cardiac		<input type="checkbox"/>	<input type="checkbox"/>
Ear/Nose/Throat		<input type="checkbox"/>	<input type="checkbox"/>
Lung		<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal		<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary		<input type="checkbox"/>	<input type="checkbox"/>
Gastroenterology		<input type="checkbox"/>	<input type="checkbox"/>
Gynecology		<input type="checkbox"/>	<input type="checkbox"/>
Breast		<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		<input type="checkbox"/>	<input type="checkbox"/>
<b>PREGNANCY HISTORY</b>			
# of Pregnancies		# _____	
Births at > 37 weeks:		# _____	
Births at <37 weeks:		# _____	
Forceps/Vacuum used: (circle)		Yes	No
Cesarean Deliveries:		# _____	
Miscarriages:		# _____	
Abortions:		# _____	
Pregnancy Complications:		_____	
<b>CURRENT MEDICATIONS (Name, Strength, &amp; Dosage)</b>			
_____			
_____			
<b>ALLERGIES</b>			
_____			
_____			