

NAME _____ DATE OF BIRTH _____

LIST ALL MEDICATIONS YOU ARE TAKING: _____

MENSTRUAL HISTORY: Age at First Period: _____ Days Bleeding: _____ Intervals: _____

CONTRACEPTIVE METHOD: _____

GYNECOLOGIC HISTORY

- Irregular Periods
- Heavy Bleeding
- Severe Cramping
- Vulvar/Cervical Warts
- Herpes
- Chlamydia
- Abnormal Pap
- Vaginal Infections
- DES Daughter

MEDICAL HISTORY – have you ever had

- Depression/Severe Anxiety
- Migraine/Severe Headaches
- Thyroid Problems
- Lung problems/Asthma
- High Blood Pressure
- Heart Disease/Palpitations
- Breast Problems
- Jaundice/Hepatitis
- Stomach/Bowel/ Gall Bladder problems
- Kidney/Bladder problems
- Anemia/Bleeding problems
- Blood Transfusions
- Diabetes
- Cancer
- Birth Defect/Inherited disease
- Seizure Disorder
- other

FAMILY HISTORY

RELATIONSHIP

- | | |
|---|-------|
| <input type="checkbox"/> Bleeding problems | _____ |
| <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Heart disease | _____ |
| <input type="checkbox"/> High blood pressure | _____ |
| <input type="checkbox"/> Kidney Disease | _____ |
| <input type="checkbox"/> Depression/Mental Illness | _____ |
| <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Deep Vein Thrombosis
(Blood clots in veins) | _____ |

Personal History: Do you smoke? _____ Drink Alcohol? _____ Exercise Regularly? _____

Are your immunizations up to date? _____

Do you want information on advanced directives? _____