PLEASE COMPLETE BOTH SIDES OF FORM

Today's Date: ____________________________________  First day of last normal period: ____________________________

At what age did your periods start? __________________ Are your periods regular?  Yes  No

On the average, how many days do you usually flow? ________  Is the flow (circle): Light  Moderate  Heavy

Date of last Pap Smear: ____________________________  Place/Facility: ____________________________

Any Abnormal Pap Smears?  No  Yes  If yes, date: __________  Place/Facility: ____________________________

Ever had a Mammogram?  No  Yes  If yes, date: __________  Any abnormal results?  No  Yes  If yes, date: ____________________________

Breast Implants?  No  Yes  If yes, date: __________  Any problems?  No  Yes  If yes, explain: ____________________________

Sexually Active?  No  Yes  If yes, circle as applicable: Oral  Vaginal  Anal

Date of last sexual contact: ________________  Was this contact protected?  Yes  No

Partner(s):  ____Male  ____Female  # of partners past 3 mos.: _____  # of lifetime partners: _____  Age first sexual intercourse: _____

Current method of contraception: ____________________________  Use of condoms (circle):  Always  Occasionally  Never

Are you concerned you may be pregnant?  No  Yes  Number of Pregnancies:____  Deliveries:____  Abortions:____  Miscarriages:____

Gynecological surgery?  No  Yes  If yes, list: ____________________________

Methods of Contraceptives you have used in the past (circle):

Cervical Cap  Condoms  Depo Provera  Problems Experienced:

Diaphragm  IUD  Norplant

Oral Contraceptives (BCP)  Ortho Evra Patch  Nuva Ring

Spermicide  Sponge  Rhythm/Fertility Method

Withdrawal  Other: ____________________________  Problems Experienced:

None of the above

Past/Current GYN Conditions (circle as applicable):

Bacterial Vaginosis (Gardnerella)  Genital Warts (HPV)  Pelvic Inflammatory Disease (PID)  Problems Experienced:

Bleeding Between Periods  Gonorrhea  Severe Menstrual Cramps

Breast Problems  Herpes (HSV)  Syphilis

Chlamydia  Nonspecific Vaginitis  Trichomonas

DES Exposure  Ovarian Disease  Yeast

None of the above

OVER  PLEASE CONTINUE ON REVERSE SIDE  OVER
GENERAL MEDICAL HISTORY (circle as applicable):

- Anemia (Iron-deficiency)
- Depression
- Headaches (Migraine/Recurrent/Tension)
- Blood clot in legs/lungs
- Eating Disorders
- High Blood Pressure
- Urinary Tract Infections (Frequent)
- None

FAMILY HISTORY - Indicate relationship of family member with condition(s) as applicable:

- Breast Cancer:
- Ovarian Cancer:
- Cervical Cancer:
- Thyroid disorder:
- Heart Attack/Angina/Stroke prior to age 50:
- Uterus removed (hysterectomy):
- Other Conditions:

LIFESTYLE HISTORY:

- Alcohol Use: No Yes
- Is your use of alcohol a concern for yourself or others: No Yes
- Balanced Diet: Yes No
- Stable Weight: Yes No
- Drug use: No Yes
- Have you used needles to inject drugs: No Yes
- Tobacco Use: No Yes
- Regular Exercise: Yes No
- History of any type of abuse: No Yes
- Other History:

List medications you are currently taking on a regular basis (include birth control pills):

Have you received the HPV Vaccine: No Yes

Have you had any new medical problems or changes in medications since your last visit: No Yes

Please note here anything in particular you want to discuss with the Practitioner:

Date of Birth: __________ Age: ______ Current Telephone Number (include area code): ____________________

PRINT NAME: ___________________ STUDENT I.D. # ____________________

Thank you very much!