PATIENT NAME:______________________________OCCUPATION:___________________________

DOB:_____________ HOME ADDRESS:____

HOME PHONE #:_______________________________CELL PHONE #__________________________

DATE COMPLETED: _______________ PRIMARY CARE PHYSICIAN:__________________________

In order for us to provide quality care to you, we ask that you fill in the answers to the questions below. All answers will be kept confidential. We'd like you to feel comfortable about discussing any questions and concerns you have with your doctor or nurse.

Reason for your visit?____

Allergies (medicine,food,other)	Reactions? (Rash, itching, swelling?)

Medications (List all medicines that you take, how, much, and how often?)

GYN HISTORY:

Date of last period: / / Interval between periods: How many days do you bleed?

Do you have any urinary problems?	NO	YES
Any abnormal bleeding?	NO	YES
Any pelvic pain?	NO	YES
Any abnormal discharge?	NO	YES
Do you have symptoms of Menopause?	NO	YES
Do you do self-breast exams monthly?	NO	YES
Do you take calcium supplements?	NO	YES
Are you sexually active?	NO	YES
Have you changed partners?	NO	YES
Do you use condoms?	NO	YES

What method of birth control do you use? None

I received a hand out on HPV NO YES

Have you been treated for sexually transmitted disease? NO YES

Gonorrhea Herpes Chlamydia HPV Syphilis hepatitis HIV other

Do you wish to be tested for any sexually transmitted disease or HIV/AIDS? NO YES

WHEN WAS THE LAST TIME YOU HAD ANY OF THE FOLLOWING : (give approximate date)

Mammogram? / /	Where?
Sigmoid/Colon exam? / /	Where?
Stool check for blood? / /	Where?
Complete Physical? / /	Where?

OB History/Surgeries/Hospitalizations (include OB history) Immunizations since your last visit:

PLEASE CHECK IF YOU HAVE BEEN DIAGNOSED WITH SINCE YOUR LAST VISIT

High blood Pressure	Breathing Problems	Blood Disorders	Alcohol Abuse	Phlebitis	Liver Disease
Diabetes	Thyroid Problems	Blood transfusions	Drug Abuse	Heart Problems	
Osteoporosis	Cancer (Gyn, Breast, Colon, other_______)	Breast Problems	Depression		
Kidney Problems	Migraine Headaches	other			

Has anyone in your family been diagnosed with the following:

Cancer (Gyn, Breast, Colon other) WHO?

Any serious illness WHO?

SOCIAL HISTORY

Martial Status? Single Married Divorced Widowed

Do you feel threatened by your current relationship? NO YES

Do you use tobacco Products?	NO	YES	IF "YES" how often?	Packs per	
Do you drink alcohol?	NO	YES	IF "YES" how often?	What kind?	How Much?
Do you use drugs?	NO	YES	IF "YES" how often?	What kind?	How Much?
Do you exercise regularly?	NO	YES	IF "YES" how often?	What kind?	How Much?

I understand that all tests ordered for me may not be covered by my insurance company.

Patient Signature: _________________________

Reviewed by: ___________________________