

<p><i>Patient Identification: Please Print.</i>                  Patient's Name: _____                  Address: _____                  Home Telephone No.: _____                  Work Telephone No.: _____                  Reason for Seeing Physician: _____</p>	<p>Date of Birth: ___/___/___ Age: ___ Religion: _____                  Relationship Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Separated <input type="checkbox"/>                  Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other <input type="checkbox"/>                  Education: ___ yrs. Race: ___ Occupation: _____                  Referring Physician: _____                  Primary Physician: _____                  Special Concerns: _____</p>
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<p>1. Current Medications: None <input type="checkbox"/>                  _____                  _____</p>	<p><b>39. Pregnancy History (complete all information)</b></p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th># of pregnancies</th> <th># of premature births</th> <th># of miscarriages</th> <th># of spontaneous abortions</th> <th># of induced abortions</th> <th># of living children</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>	# of pregnancies	# of premature births	# of miscarriages	# of spontaneous abortions	# of induced abortions	# of living children						
# of pregnancies	# of premature births	# of miscarriages	# of spontaneous abortions	# of induced abortions	# of living children								

<p>2. Medication Allergies/Sensitivities:                  _____                  _____</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>Born mm/yy</th> <th>M / F</th> <th>Birthweight</th> <th>Weeks pregnant</th> <th>Hours in labor</th> <th>Type of delivery</th> <th>Anes.</th> <th>Complications</th> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>	Born mm/yy	M / F	Birthweight	Weeks pregnant	Hours in labor	Type of delivery	Anes.	Complications																																
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- | MEDICAL HISTORY:                                | YOU                      | FAMILY                   |
|-------------------------------------------------|--------------------------|--------------------------|
| 3. Depression.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Psychiatric Problems.....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. High Cholesterol.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Heart Disease.....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Rheumatic Fever.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. High Blood Pressure.....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Asthma.....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Tuberculosis.....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Diabetes.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Thyroid Problems.....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Liver Disease.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Stomach, Bowel or Gallbladder Problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Kidney or Bladder Problems.....             | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. AIDS (HIV).....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Hepatitis (type___).....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Anemia or Blood Disorder.....               | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Blood Transfusion.....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Deep Vein Thrombosis...                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Stroke.....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Allergies.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Breast Problems.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Cancer.....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Female or Sexual Problems.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Infertility.....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Chlamydia.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Gonorrhea.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Herpes (HSV).....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Syphilis.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Birth Defects.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Inherited Diseases.....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Sexual Abuse.....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Domestic Violence.....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Other Med. Problems.....                    | <input type="checkbox"/> | <input type="checkbox"/> |

**40. Menstrual History**

First Day of Last Menstrual Period: \_\_\_/\_\_\_/\_\_\_

Menarche (Age at First Period)	Interval (# of Days Between Periods)	Length of period
Days	Days	Days

Abnormalities:  excessive bleeding  
 discharge  pain  none

**41. CONTRACEPTIVE HISTORY**

Type	Dates Used
Oral Contraceptive	<input type="checkbox"/> _____
Type(s)_____	<input type="checkbox"/> _____
	<input type="checkbox"/> _____
IUD.....	<input type="checkbox"/> _____
Diaphragm.....	<input type="checkbox"/> _____
Norplant.....	<input type="checkbox"/> _____
Sponge.....	<input type="checkbox"/> _____
Spermicide.....	<input type="checkbox"/> _____
Condoms.....	<input type="checkbox"/> _____
Other_____	<input type="checkbox"/> _____
Sterilization <input type="checkbox"/> Male <input type="checkbox"/> Female	

**LIFESTYLE**

	Yes	No
42. Did your mother take DES or any other when pregnant with you?.....	<input type="checkbox"/>	<input type="checkbox"/>
43. Have you ever had a pap test?..... If yes, give the date of your last Pap test: ___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had abnormal Pap results?.... If yes, when: ___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
44. Are you sexually active?.....	<input type="checkbox"/>	<input type="checkbox"/>
45. Do you have one partner or ..... many partners?..... with men, women or both?	<input type="checkbox"/> one <input type="checkbox"/> 2 or more	
46. If sexually active, do you participate in vaginal sex	<input type="checkbox"/>	<input type="checkbox"/>
oral sex	<input type="checkbox"/>	<input type="checkbox"/>
anal sex	<input type="checkbox"/>	<input type="checkbox"/>
47. Is intercourse painful for you?.....	<input type="checkbox"/>	<input type="checkbox"/>
48. Do you do monthly self-breast exams?....	<input type="checkbox"/>	<input type="checkbox"/>
49. Have you ever had a mammogram?..... If yes, date of last mammogram: ___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
50. Do you exercise on a regular basis?..... If yes, Type of exercise _____ Hours per week _____	<input type="checkbox"/>	<input type="checkbox"/>

37. HOSPITALIZATIONS: List surgeries and hospital confinements for serious illnesses. If more than six, check here . Do not include pregnancies in this section.

Month / Year	Illness or Surgery	Complications	
		Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

38. SUBSTANCE USE: Check only those you use

Substance	Type	Amt./day
Alcohol		
Tobacco		
Caffeine		
Non-prescribed Drugs		
Street Drugs		

Provider's Signature: \_\_\_\_\_

