PERSONAL HISTORY FORM

Please bring this form to the office along with a list of *any current medications with name and dosage, including vitamins and supplements.*

NAME: _____ _____ AGE: _____ DATE: _____

WHAT BRINGS YOU TO THE OFFICE TODAY? _____ _____

ARE YOU PREGNANT? Y N

GYN HISTORY

First day of your last period:_____ Age at first menstruation_____ Age at menopause_____

Are you **currently** taking birth control pills (patch/ring) **Y** for _____ months/years **N**

Or hormone replacement therapy? **Y** for _____months/years **N**

If not, how often do you get your period? Every _____ days; How long does it last?_____ days

Do you usually use pain medication with your period? **Y N** Do you suffer from PMS? **Y N** Date of last Pap_____

Breast exam_____ If applicable: Mammogram_____ Bone densitometry_____ Colonoscopy _____

Ever been pregnant? **Y N** If yes, outcome: # births:_____ # Miscarriages, Abortions, Ectopic Pregnancies_____

Living Children _____ Any Complications? _____

Personal history of GYN disorders, e.g: GYN Cancer/Endometriosis/Fibroids/Excessive Menstruation/Ovarian Cysts

Other_____

SEXUAL HISTORY/RISK ASSESSMENT

Have you ever had sex? **Y N** Age at first intercourse_____

Currently sexually active with men/women/both? (Please circle one)

More than one partner in the last year? **Y N** What method do you use to prevent pregnancy? _____

Have you ever had a sexually transmitted disease? **Y N** If yes, which? _____

Have you ever had an abnormal Pap smear? **Y N** Colposcopy/Cryo/LEEP? Year_____

Have you ever been tested for HIV? **Y N** Would you like a test today? **Y N** Would you like tests for other STDôs today? **Y N**

Have you been vaccinated with Gardasil against HPV? **Y N**

Are you a survivor of sexual assault or incest? **Y N** Is there violence in any of your relationships? **Y N**

PERSONAL MEDICAL HISTORY

Do you have/have you had any medical problems? If yes, please circle:

Anxiety - Asthma ï Allergies - Bleeding Disorder ï Depression- Diabetes- Eating Disorder - Heart Disease -High Blood Pressure High Cholesterol - Migraine Headaches -Thyroid Problems - Seizures Bowel Disease - Urinary Tract Infections

Cancer (which organ?_____) Other_____

Do you currently take any medications or supplements? If yes, which _____

Are you **allergic** to any **medications**? Y N If yes, which _____

Have you ever had any **surgery**? Y N If yes, which type? _____

FAMILY MEDICAL HISTORY

Do/did your PARENTS OR SIBLINGS have any of the following? If yes, please circle:

High cholesterol - Stroke - Blood Clots - Diabetes - Heart Disease - High Blood Pressure - Breast Cancer - Uterine Cancer - Ovarian Cancer - Colon Cancer

HABITS

Do you smoke cigarettes? **Y N** Do you drink alcohol? **Y N** Do you use recreational drugs? **Y N**