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Name__________________________________**Age**____________**Date of Birth**_________________**Today's Date**______________________

Marital Status M S D (circle) Occupation____

Referred by____

Present Symptoms

______Nausea/Vomiting

______Abdominal Pain

______Abnormal/Irregular Bleeding

______Vaginal Discharge

______Urinary Problems

Menstrual History

Age at Onset of Periods________

Date of Last Period____________

Regular or Irregular___________
If Irregular: Shortest Cycle_______# days
Longest Cycle________# days
Amount of Flow: Normal Light Heavy (circle)
Cramping with Period: Yes No (circle)
If yes: Moderate Severe Normal (circle)

Contraception	**Past**	**Present**
IUD	_____	______
Diaphragm	_____	______
Foam, Condoms, Sponge	_____	______
Norplant	_____	______
Inserted	_____/_____/______	
Removed	_____/_____/______	
Birth Control Pills	_____	______
Brand Name	__________________	
Tubal Ligation	_____/_____/_____	
Partner with Vasectomy	Yes	No (circle)

Family History	**Self**	**Family**
Breast Problems	_____	_____
Mental Disorders	_____	_____
Seizures	_____	_____
Diabetes	_____	_____
Heart Disease	_____	_____
High Blood Pressure	_____	_____
Cancer	_____	_____
Lung Disease/TB	_____	_____
Kidney Disease	_____	_____

Other___________________________________
____

Pregnancy History
Please List Number of:
Premature Births_______ Miscarriages________
Abortions_______________ Living Children______

Gravida__________Para__________
(office use only)

No.	Born Mo/Yr	Weight At Birth	Sex	Type of Delivery	Labor Hours	Complications
1.						
2.						
3.						
4.						
5.						

Name____ Date of Birth__________________________

Surgical History, please list:

No.	Mo/Yr	Procedure	Physician	Complications
1.				
2.				
3.				
4.				
5.				

Past Medical History	**Yes**	**No**		**Yes**	**No**
1. Serious Accident	____	____	11. Blood Clot in Leg	____	_____
2. Hospitalizations	____	____	12. Varicose Veins	____	_____
3. Vision/Hearing Problem	____	____	13. Sexually Transmitted Disease	_____	_____
4. Headaches	____	____	14. Herpes	_____	_____
5. Thyroid Disease	____	____	15. Pelvic Disorders	_____	_____
6. Asthma	____	____	16. Blood Transfusion	_____	_____
7. Rheumatic Fever	____	____	17. Drug Use	_____	_____
8. Ulcers/Colitis	____	____	18. Alcohol Use	_____	_____
9. Hepatitis/Jaundice	____	____	19. Tobacco Use	_____	_____
10. Bladder Infection	____	____	No. packs per day	______________	
			No. years smoked	______________	

Drug Allergies

List any drug that has caused you to have an allergic reaction such as rash, hives or difficulty breathing. Note that uncomplicated nausea, stomach upset or short term vomiting does not constitute an allergic reaction. If you have been unable to tolerate a medication because of a minor side effect, list it as an adverse reaction.

Drug Name **Explain Allergic Reaction**

____

____

____

Drug Name **Explain Allergic Reaction**

____

____

____

List Any Medications (prescription and/or non-prescription) you are currently taking

Name of Medication	Dosage	Times taken daily	Name of Medication	Dosage	Times taken daily

1.____ 4.____

2.____ 5.____

3.____ 6.____