



DATE: NAME: DATE OF BIRTH: AGE:

PREFERRED NAME (How should we address you?): YOUR PROFESSION:

WHY ARE YOU HERE TODAY? Who referred you?

ALLERGIES (to medications or food): [] No Known Drug Allergies YOUR PRIMARY CARE PROVIDER: [] Send today's visit note to PCP

OBSTETRIC/GYNECOLOGIC HISTORY MENSTRUAL HISTORY (Skip if you are postmenopausal or have had a hysterectomy) [] N/A

First day of last period: Age when you got your first period: # of days between periods: (i.e. from the start of one period to the start of the next period) # of days you bleed: Amount of bleeding? [] heavy [] medium [] light Painful periods? [] no [] yes Any problems with period? [] no [] yes - Explain:

SEXUAL HISTORY

I have sex with: __ male partner(s) __ female partner(s) [] not active If you have/had intercourse, __ male and/or female partner(s) __ FTM partner(s) __ MTF partner(s) age at first time: I have had, or my partner has had, new partner(s) since last health care visit: [] no [] yes [] not active since then With sexual activity, do you have: [] pain [] bleeding Date of last Pap: Where was Pap? Please list any questions/concerns:

PREGNANCY HISTORY [] No pregnancies

of full-term pregnancies: # of premature pregnancies: # of vaginal births: [] forceps/vacuum? # of c-sections: # of miscarriages: # of abortions: # of ectopic pregnancies: # of living children: # of children placed for adoption: # of children adopted:

CONTRACEPTIVE HISTORY [] N/A

If you use a birth control method, what is it? Problems with it? [] no [] yes: Other methods used in past: Interested in changing methods? [] no [] yes

MENOPAUSE AND BEYOND [] N/A

Age you stopped having periods: Problems or concerns? [] no [] yes: Taking hormone therapy or other remedies? [] no [] yes - Please list:

GYNECOLOGIC HISTORY - Check if you have or have had

[] Abnormal uterine bleeding [] Fibroids [] Endometrial polyps [] Endometriosis [] Pelvic pain [] Ovarian cysts or tumors [] Infertility issues Loss of: [] urine [] stool [] both [] Premenstrual syndrome [] Vaginitis (yeast, BV, other) [] Pelvic infection/PID Herpes: [] oral [] genital [] Chlamydia [] Gonorrhea [] "Trich" Do you douche? [] no [] yes [] Vulvar skin problem: [] DES exposed [] Genital warts [] Abnormal Pap smear [] HPV [] Colposcopy [] LEEP or Cone [] Cryotherapy When? Result?

Details:

HEALTH AND NUTRITION

I exercise times per week. Types of exercise I do: I eat a well balanced diet [] no [] yes I eat servings of fruits & vegetables per day (serving = 1/2 cup) I take calcium &/or eat calcium-rich foods [] no [] yes - Amount/sources? I take Vitamin D [] no [] yes - Amount/sources? I drink alcohol [] no [] yes - What? How much? How often? I smoke tobacco products [] no [] yes How many packs/day? [] Ex-smoker [] Year quit: I use other drugs [] no [] yes - Which one(s)?



DATE:

NAME:

DOB:

AGE:

MEDICAL AND FAMILY HISTORY

I have no knowledge of my family history

Please note which family member(s) was/were affected for each condition. Use extra space below if needed.

Table with 9 columns: Check if yes, Self, Family, Check if yes, Self, Family, Check if yes, Self, Family. Rows include Breast cancer, Ovarian cancer, Colon cancer, Uterus cancer, etc.

SURGERIES, HOSPITALIZATIONS, ACCIDENTS &/OR SERIOUS ILLNESSES

Table with 4 columns: Description, YEAR, Description, YEAR. For recording surgical and medical history.

MEDICATIONS, VITAMINS, HERBS AND SUPPLEMENTS (Include doses and frequency if known)

Large empty box for listing medications, vitamins, herbs, and supplements.

PREVENTION & SCREENING

VACCINATION RECORD

- I have had the tetanus vaccine within last 10 years
I have had the HPV vaccines as child, teen or young adult
I have had measles, mumps, and rubella or was vaccinated
I have had chicken pox or was vaccinated
I have had the Hepatitis B vaccinations
If over 60, I have had the shingles vaccine
If over 65, I have had the Pneumovax vaccine
I have had the meningitis vaccine
Other:

DOMESTIC VIOLENCE - As we are concerned about your safety and because it is so common, we ask all our patients about the presence of violence and abuse in their home. Are you being:

- Hurt?
Insulted or talked down to?
Screamed or cursed at?
Threatened with physical harm?
I have a history of sexual abuse/battering

Table for screening tests: Cholesterol test, Mammogram, Colonoscopy, Bone density/DXA, Other(s). Columns include no/yes, When?, Where?, Result?.

I have written advanced directives

I would like a written summary of today's visit posted to my patient portal