NAME: _____

TODAY'S DATE: _____ DATE OF BIRTH: _____

HISTORY (To be completed by patient)

Reason for Visit: Routine exam ( ) Yes ( ) No
Describe Problem

Date of last period _____If Postmenopausal, any bleeding in past year? _____
Age periods started _____ Usual # of days between periods _____ ( ) Regular ( ) Irregular
Duration _____ days Usual Flow: ( ) Scant ( ) Moderate ( ) Heavy
Pain: ( ) None ( ) Mild ( ) Moderate ( ) Severe
Medication taken for pain _____
Any bleeding/spotting between periods? ( ) Yes ( ) No
Current Method of Birth Control _____ Any Problems? ( ) Yes ( ) No

Any Gynecologial Surgeries? ( ) Yes ( ) No
If Yes, Type? _____
If a Hysterectomy: ( ) Total (both ovaries taken) ( ) Partial (ovaries left)
Reason? _____

Date of Last Pap Smear _____ Date of Last Mammogram _____
Any Abnormal Paps in the Past? ( ) Yes ( ) No Type and Treatment _____
History of any Sexually Transmitted Diseases? ( ) Yes ( ) No Type?_____
Number of sexual partners in the past year _____ Lifetime _____
Men _____ Women _____ Both _____
Pregnancy History: ( ) None Number of : Full term births _____ Premature births _____
Miscarriages _____ Abortions _____
If Postmenopausal, are you on hormones? ( ) Yes ( ) No
Type _____ Number of Years _____
Have you ever had a Bone Density Test? ( ) Yes ( ) No If yes, date and results _____

Do you currently or have you had in the past:

| | | | | | |
|---|---|---|---|---|---|
| Breast cancer | ( ) Yes | ( ) No | Blood clots | ( ) Yes | ( ) No |
| Liver problems | ( ) Yes | ( ) No | Migraines | ( ) Yes | ( ) No |

Do you smoke? ( ) Yes ( ) No Packs per day? _____
Do you use alcohol? ( ) None ( ) Moderate ( ) Heavy
Have you ever had a problem with drug abuse? ( ) Yes ( ) No
Exercise regularly? ( ) Yes ( ) No Occupation? _____

**Any Family History of:**

| | | | |
|---|---|---|---|
| Breast Cancer | ( ) Yes | ( ) No | Who? _____ |
| Ovarian Cancer | ( ) Yes | ( ) No | Who? _____ |
| Cervical Cancer | ( ) Yes | ( ) No | Who? _____ |
| Uterine Cancer | ( ) Yes | ( ) No | Who? _____ |
| Colon Cancer | ( ) Yes | ( ) No | Who? _____ |
| Osteoporosis | ( ) Yes | ( ) No | Who? _____ |

Early (< age 65) heart disease/heart attack ( ) Yes ( ) No Who?_____