Patient Name: _____ **Preferred Name :** _____

Gender Identity: ☐ Female ☐ Male ☐ Other (specify) _____

Allergies: _____

Prescribed Medications: _____

MEDICAL PROBLEMS:

☐ Hypertension ☐ Hypothyroidism ☐ Cholesterol ☐ Depression ☐ Anxiety ☐ Asthma

☐ Diabetes ☐ Endometriosis ☐ Bone Loss (osteopenia/ osteoporosis) ☐ Migraines ☐ Aura

PAST SURGICAL HISTORY:

☐ Tonsils ☐ Appendix ☐ Gall Bladder ☐ D&C/Hysteroscopy ☐ LEEP ☐ C-Section(s) ____#

☐ Tubal Ligation ☐ Hysterectomy ☐ Laparoscopy ☐ Endometrial Ablation

Other: _____

FAMILY HISTORY:

List anyone in your immediate family with the following conditions, (include age at the time of diagnosis):

☐ Breast Cancer _____ ☐ Uterine Cancer _____ ☐ High Blood Pressure _____

☐ Ovarian Cancer _____ ☐ Colon Cancer _____ ☐ Diabetes Melitus _____

SOCIAL HISTORY:

Do You Smoke? Yes / No **How many packs a day?** _____ **Quit Date:** _____
Alcohol Use: ☐ Never ☐ Occasional ☐ Weekly ☐ Daily (____ # per day)
Do you Vape? Yes / No **Do you use Marijuana?** Yes / No **Other Drug Use?** Yes / No

GYN HISTORY:

Do your menstrual cycles come at regular intervals: ☐ Yes ☐ No
What age did you start having menses? _____ **What age did your cycles stop?** _____
Year of your last pap: _____
Have you ever had an abnormal Pap smear? ☐ Yes ☐ No **If Yes, what year** _____

Total Number of pregnancies? _____ **No. of Vaginal Deliveries** _____ **No. of C-Sections** _____
Have you had any of the following and how many:
☐ Miscarriages ____ ☐ Abortions ____ ☐ Ectopic Pregnancies _____
Have you received the Gardasil Vaccine? ☐ Yes ☐ No

Last Mammogam, Date and Location: _____

Have you ever been treated for ☐ Chlamydia ☐ Gonorrhea ☐ Genital Warts ☐ Herpes
Are you sexually active: ☐ Yes ☐ Not Presently ☐ Never
Sexual Preference: ☐ Heterosexual ☐ Homosexual ☐ Other: _____
Are you currently using birth control? ☐ No ☐ Yes, Current birth control is _____