Name_____
Date of birth/Age_____
Date of last period_____
Referred by_____
Reason for visit_____
Height _____
Weight_____

OB History
Number of pregnancies:

Delivery Date	Outcome	Delivery type	weight	With current partner Yes or No

GYN History
Periods since age of _____, occur every _____days and last ____days
Painful period _____yes _____no
Last pap smear_____
Abnormal pap smears _____yes _____no _____if yes – when? _____
History of pelvic inflammatory disease _____yes _____no
History of sexually transmitted diseases ____yes _____no
Pelvic pain ____yes ____no
Contraception history ____none _____or list below:
_____
_____
_____

Past Medical History (diabetes, high blood pressure…):

Have you been checked for or vaccinated for (choose option):

Rubella

1. Has had 2.Been checked for 3.Been vaccinated for

Varicella (chicken pox)

1. Has had 2. Been checked for 3. Been vaccinated for

Have you had:

Gardasil (HPV) vaccine __yes __no

Past surgical History:

_____

_____

Medications (including supplements):

_____

_____

Allergies:

_____

Social History

Smoking _____none or _____packs per day

Alcohol _____none or _____drinks per week

Drugs _____none or_____

Occupation_____

Family History (diabetes, cancer, heart disease…):

_____

_____

Sexual Function

Are you sexually active _____ yes _____no

Any sexual problems _____ yes _____no

If yes, please list_____

_____

_____