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____

____

____