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NAME: _____ AGE_____

DATE: _____

OCCUPATION: _____

New Patient History

Drug Allergies_____

Circle reason for today's visit Annual Exam Menopause Consultation Menstrual Problem Pain Discharge Possible Pregnancy Birth Control
Other:_____

Your Medical History (List all illnesses, and the year of onset)

_____

_____

_____

Your Surgical History (List all surgeries and year performed)

_____

_____

_____

Current Medications including contraceptives

Med_____ Dose_____ Med_____ Dose_____
Med_____ Dose_____ Med_____ Dose_____
Med_____ Dose_____ Med_____ Dose_____
Med_____ Dose_____ Med_____ Dose_____

Menstrual History

Started Age _____ regular _____irregular _____ other_____
First day of last period or date of onset of menopause_____
Average days between periods_____ Average days of bleeding_____ Heavy?_____
Any bleeding between periods?_____ Any bleeding after intercourse?_____
Any Pain with Intercourse?_____ Time with present Partner _____
What vaginal infections or STDs were treated in the past?_____
Date of last Pap smear_____ Any abnormal Pap smears?_____
Treatment for abnormal pap smears (please circle)? LEEP Freezing Cervix Cervical biopsies

OB History

Male or Female Year Born Months of Preg Labor duration Birth Weight Complications

Menopause History

Age at Menopause_____ Ever on Hormone Replacement? _____

Reason for HRT: Hot Flashes Night Sweats Insomnia Vaginal Dryness Other_____

List hormone therapy and duration_____

Family History	List relative	Age at Diagnosis	Current Status
Breast Cancer	_____	_____	_____
Colon Cancer	_____	_____	_____
Ovarian Cancer	_____	_____	_____
Heart Disease	_____	_____	_____
High BP	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid disease	_____	_____	_____
Osteoporosis	_____	_____	_____

Social History

Alcohol Never Social Daily Current Use#_____/week

Tobacco Never Quit Current Smoker Number cigarettes/ day_____

Age at starting smoking_____ Age at quitting smoking_____

Regular Exercise? _____

Are you? Single Married Divorced Separated Caregiver Have Pets?

Screening History

Blood Work	Date_____	Results_____	Due_____
Pap/HPV	Date_____	Results_____	Due_____
Mammogram	Date_____	Results_____	Due_____
Bone Density	Date_____	Results_____	Due_____
Colonoscopy	Date_____	Results_____	Due_____
Other	Date_____	Results_____	Due_____

Symptom Review-circle all that apply or write in

General	Weight Gain Weight Loss Poor Sleep Fatigue
HEENT	Snoring Sleep Apnea Allergies Loss of Hearing Visual Changes
Heart	Chest Pain Heart Trouble Palpitations
Lungs	Cough Short of Breath Asthma
Digestion	Abdominal Pain Nausea Vomiting Constipation Diarrhea Bloating Heartburn/reflux Food intolerance
Urination	Frequent urination Urinary Urgency Loss of Urine Kidney Stones
Gynecology	Pelvic Pain Hot Flashes Night Sweats Vaginal dryness Pain with intercourse Vaginal discharge Pelvic Pain No Desire
Muscle/Joints	Muscle Pain Joint Pain Back Pain Neck Pain
Neurology	Migraines Memory changes Anxiety depression
Other	Chemically Sensitive Hair Loss Hot/Cold intolerance Excess Hair