Name: ____ Date of Birth: _______________ Age: ________ Today's Date: ________________________

ALL INFORMATION IN OUR OFFICE IS CONFIDENTIAL

Please state the reason for your visit today. ____

Date of your last Pap Smear test: _________________________________ Was it normal? □ Yes □ No

If not, please explain testing done:

Colposcopy/ LEEP/ Cryo/ Laser ____________________________

Date of your last Mammogram: ___________________________ Do you self-examine your breasts? □ Yes □ No

Do you understand how to do this exam? □ Yes □ No

Age of your 1st period: ____ First date of last period: ________ Length of time between periods _____ Bleeding how many days ______

Please state any problems with your period. ____

Current method of Birth Control: ____________________________________ If none, do you wish to discuss birth control today? ________

Past methods of Birth Control: ____ Any problems? ______________________________________

Are you pregnant or nursing? ____

Are you trying to get pregnant now or in the immediate future? □ Yes □ No

Are you interested in Pre-Conception counseling? □ Yes □ No

If you are Menopausal: At what age did you stop menstruating? ____

Do you take any Hormone Replacement Therapy? ____

Fosamax ________________ Calcium ________________ Vitamin D ________________ Magnesium ________________

Health Food Store Therapies: ____

Have you had a Bone Density Test? ________________ Results? ____

Pregnancy History: Full Term _________ Premature (before 37 wks.) _________ Miscarriage _________ Induced Abortions _______

Deliveries:

Month / Year	Length of Pregnancy	Length of Labor	Vaginal / Caesarean	Sex	Weight	Hospital

Please note any complications to you or your baby. Please explain ____

____

Surgeries/ Hospitalizations (Including Facial):

Year	Reason	Hospital	Doctor	Follow-Up

History of previous non-surgical facial procedures or injections: ____

History of facial trauma: ____

PLEASE COMPLETE BACK OF FORM

Social History:

Substance	Amount / Type	Per Day / Week
Alcohol		

Drugs		
Other		

Have you been treated for:

Abnormal Pap Smear ______ Chlamydia ______ Gonorrhea ______ Condyloma ______ Herpes ______ PID ______ HIV ______ HPV ______

Medical History	**Patient**	**Family Member(relation)**	**Comment**
Breast Cancer			
Cervical Cancer			
Ovarian Cancer			
Colon Cancer			
Pancreatic Cancer			
Stomach Problems / Ulcers			
Jaundice / Hepatitis			
Diabetes			
Thyroid Disorders			
Heart Disease			
Heart Attack / Stroke			
High Blood Pressure			
Anemia / Hereditary Blood Disorders			
Varicose Veins / Phlebitis			
Migraines			
Neurological Disorders			
Asthma / Hay Fever			
Urinary Tract Infections			
Psychological Problems			
Other			

In addition to your physical well-being, our office asks a very personal question for your physical safety. We feel that women's healthcare is more than "just an exam and a pap smear".

Are you now or have you been in a physically or verbally abusive relationship? ◻ Yes ◻ No

Do you want any assistance at this time for yourself or family member? ◻ Yes ◻ No

Please state any particular concerns not covered in your above history.

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Patient / Guardian Signature Medical History Reviewed By