Patients Name______________________________ Date of Birth_____________ Age ________ Today's Date______________

With Whom may we discuss test results or therapies?____

1. GYNECOLOGICAL HISTORY: Any gynecological problems since your last examination? ☐ Yes ☐ No (if yes please explain)

-First day of last period ____________________ Date of last Mammogram ______________________

-Duration of Flow ________________________ Date of last Pap Smear ________________________

-Time between periods ____________________ Are you sexually active? _______________________

-Date of last Bone Density Scan _____________ Do you use contraception? _____________________

2. MEDICAL HISTORY: Any medical problems since your last examination? ☐ Yes ☐ No (if yes please explain)

-Do you take calcium? ☐ Yes ☐ No

-List current Medications (include vitamins and herbal supplements) ____

-List any allergies to Medications ____

-Any Surgeries/Hospitalizations since your last examination? (if yes please explain): __________________________________

3. FAMILY HISTORY: Any changes to your family history since your last examination? ☐ Yes ☐ No (if yes please explain)

4. SOCIAL HISTORY: Any changes to your social history since your last examination? ☐ Yes ☐ No (if yes please explain)

-Do you exercise regularly? ☐ Yes ☐ No Current Occupation: ________________________________

-Marital Status ☐ single ☐ married ☐ separated ☐ divorced ☐ widow ☐ other

-Do you Smoke Cigarettes: ☐ Yes ☐ No If yes at what age did you start________ Packs per day _______

-Do you drink alcohol? ☐ Yes ☐ No IF yes, amount? _________ If yes, how often? _____________

-Do you use drugs socially? ☐ Yes ☐ No IF yes, type___________________ IF yes, how often? __________________

-Are you a victim of domestic violence or abuse in your present relationship? ☐ Yes ☐ No Past relationship? ☐ Yes ☐ No

-Do you have a living will? ☐ Yes ☐ No

5. REVIEW OF SYSTEMS

-Abdomen:	Diarrhea	☐ Yes ☐ No	Constipation?	☐ Yes ☐ No	Other: __________________
-Genitourinary:	Frequent urination?	☐ Yes ☐ No	Urinary Incontinence?	☐ Yes ☐ No	Other: __________________
-Skin/Breast:	Lumps in breast?	☐ Yes ☐ No	Nipple discharge?	☐ Yes ☐ No	Other: __________________

Any other Problems?

Completed by____Date:____________________________________

Reviewed by ____ Date ____________________________________
(signature of Provider)