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We are currently updating our patient information. Please take a few minutes to answer the following questions. Thank you.

NAME: _____ DATE: _____ AGE: _____ DOCTOR: _____

MEDICATIONS: Please list your current medications including vitamins and herbal supplements.

Medication	Reason for Medication	Amount/Dose	How Many Times Daily	Who prescribed this medication?

Medication Allergies: List all, including allergies to latex, Iodine/Betadine.

No known drug allergies

Drug Name	Reaction

PERSONAL MEDICAL HISTORY: Please indicate current or prior medical problems.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Abnormal mammogram | <input type="checkbox"/> Bacterial vaginosis | <input type="checkbox"/> Herpes | |
| <input type="checkbox"/> Breast lump or mass | <input type="checkbox"/> Yeast infections | <input type="checkbox"/> Gonorrhea | |
| <input type="checkbox"/> Fibrocystic breast disease | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Pelvic inflammatory disease | |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Genital warts | <input type="checkbox"/> Infertility | |
| <input type="checkbox"/> Abnormal Pap smear | <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Overactive thyroid |
| <input type="checkbox"/> Cervical dysplasia | <input type="checkbox"/> Seizures | <input type="checkbox"/> Blood clots (<i>Deep vein thrombosis</i>) | <input type="checkbox"/> Underactive thyroid |
| <input type="checkbox"/> Cervical cancer | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Cervical polyp | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Elevated blood pressure | <input type="checkbox"/> Mitral valve prolapse |
| | | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Bartholin gland abscess or cyst | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Fibroids of the uterus | <input type="checkbox"/> Polycystic ovaries |
| <input type="checkbox"/> Uterine cancer | <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Leaking urine (<i>Urinary incontinence</i>) | <input type="checkbox"/> Blood transfusions |
- Other medical problems _____
- No significant medical problems

THE HEALTH PLAZA AT ST. MARYS

SCREENING TESTS:

Screening Test	Date	Results
Pap Smear		
Mammogram		
Bone Density		
Cholesterol		
Colonoscopy		

PAST SURGICAL HISTORY: List all surgeries including procedures to the cervix. No Surgeries

Procedure	Date

GYNECOLOGIC HISTORY:

Age at first period: _____ Cycle interval (From first day of one period to first day of next): _____ Days of flow: _____

Amount of flow: Heavy, Moderate, Light First day of last period: _____ Contraceptive method: _____

Clots with cycles? Y N

Bleeding between periods? Y N

If menopausal, age at onset: _____

PREGNANCY HISTORY: (If never pregnant, disregard this section)

Total number of pregnancies: _____ Number of deliveries: _____ Abortions: _____

Number of premature deliveries: _____ Ectopic pregnancies: _____ Miscarriages: _____

CHILDREN:

Name	Date	Birth Weight	Sex	Vaginal or C-section?	Anesthesia	Early Labor	Complications	Location

FAMILY HISTORY: Please indicate diseases in your immediate family. Include which family member was affected. Bleeding disorders _____ High blood pressure _____ High cholesterol _____ Cardiac defects _____ Cervical cancer _____ Mental retardation _____ Cleft lip _____ Breast cancer _____ Colon cancer _____ Cleft palate _____ Ovarian cancer _____ Uterine cancer _____ Cystic fibrosis _____ Spina bifida or Anencephaly _____ Sickle cell anemia _____ Down syndrome _____ Diabetes _____ Heart disease _____ Other significant diseases in the family: _____

SOCIAL HISTORY: Circle the term that best describes your habits.

Marital Status:	Married	Single	Divorced	Widow
Alcohol Use:	Frequent	Never	Occasional	
Self-breast exam:	Irregular	Regular (monthly)	Not done at all	
Caffeine Intake:	None	1-2 drinks/day	3 or more per day	
Diet:	1000 mg calcium daily	less than 1000 mg calcium daily		
Domestic Violence:	Current	Never	Prior	
Drug Use:	Current	Never	Prior	
Exercise:	1-2 x per week	3 or more x per week	None	Sporadic
Seatbelt Use:	Not regular	Always		
Smoker:	Current	Never	Prior	
Patient Signature:	_____			Date: _____

1. Have you seen or heard advertisements for Women's Clinic? yes no

2. If you answered yes to the questions above, please check all that apply:

newspaper television radio special event

3. Who referred you to Women's Clinic? friend relative physician self