To reproduce, follow the printing instructions. Do not fold this form.

Direction of Feed

Personal / Family History

Please answer every question

Do not write, stamp, punch holes or affix a sticker in this area.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH Month Day Year

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

GYNECOLOGICAL HISTORY

Do you have menstrual periods? yes ○ no (hysterectomy) ○ no (postmenopausal) ○ no (other) ○

Do you have problems with your periods? yes ○ no ○

Have you had an abnormal pap in the past 5 years? yes ○ no ○

Current contraception (mark all that apply)**:**
vasectomy ○ tubal ligation ○ contraceptive ring ○ contraceptive patch ○ intrauterine device (IUD) ○ Depo-Provera© ○ Nexplanon / Implanon ○ oral contraceptives ○ condoms ○ other ○ **NONE** ○

Are you currently sexually active? yes ○ no ○

Have you ever been sexually active? yes ○ no ○

Have you ever had a sexually transmitted disease? yes ○ no ○

If yes, which type(s): HPV ○ genital warts ○ gonorrhea ○ syphilis ○ herpes ○ chlamydia ○ other ○

please fold on dotted line

OBSTETRICAL HISTORY

	0	1	2	3	4	5	6	7	8	9	10+
TOTAL number of pregnancies (include current pregnancy)	○	○	○	○	○	○	○	○	○	○	○
Number of VAGINAL deliveries (after 20 weeks)		○	○	○	○	○	○	○	○	○	○
Number of living children		○	○	○	○	○	○	○	○	○	○
Number of premature deliveries (less than 36 weeks)		○	○	○	○	○	○	○	○	○	○
Number of stillbirths (after 20 weeks)		○	○	○	○	○	○	○	○	○	○
Number of miscarriages		○	○	○	○	○	○	○	○	○	○
Number of elective abortions		○	○	○	○	○	○	○	○	○	○
Number of ectopic pregnancies		○	○	○	○	○	○	○	○	○	○
Number of Cesarean Sections		○	○	○	○	○	○	○	○	○	○

Reason for Cesarean Sections: (mark all that apply)
herpes ○ breech ○ failure to progress ○ oversized baby ○ fetal distress ○ repeat C-section ○ other ○

Have you had any complications during pregnancies? no ○ yes ○

If yes, please mark all complications:
breech ○ bleeding ○ pre-term delivery ○ high blood pressure ○ diabetes ○ premature labor ○ pre-term rupture of membrane(s) ○ other ○ **NONE** ○

Have you had any problems getting pregnant? yes ○ no ○

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PATIENT HISTORY

Please indicate if you have had any of the following:

- ○ Colon Cancer
- ○ Breast Cancer
- ○ Lung Cancer
- ○ Ovarian Cancer
- ○ Uterine Cancer
- ○ Other Cancers
- ○ Depression
- ○ Diabetes
- ○ High Blood Pressure
- ○ Heart Disease
- ○ Kidney Disease
- ○ Osteoporosis
- ○ Stroke
- ○ Thyroid Disease
- ○ Weight Disorders
- ○ Seizures
- ○ Respiratory Disease
- ○ Headaches (Migraine)
- ○ Blood Clots
- ○ Psychiatric Care
- ○ PMS
- ○ Endometriosis
- ○ Frequent Bladder Infections
- ○ Uterine Fibroids
- ○ Recurrent Ovarian Cysts
- ○ Anesthetic Complications
- ○ Autoimmune Disorder
- ○ Blood Transfusions
- ○ Hepatitis / Liver Disease
- ○ Infertility
- ○ Other Medical Problems

○ **NO SIGNIFICANT MEDICAL HISTORY**

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Personal / Family History

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FAMILY MEDICAL HISTORY

Please indicate which family members have had these illnesses:

○ **FAMILY HISTORY UNKNOWN**

○ **NO SIGNIFICANT FAMILY MEDICAL HISTORY**

	Mother	Father	Sister	Brother	Daughter	Son
Colon Cancer	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○
Lung Cancer	○	○	○	○	○	○
Ovarian Cancer	○		○		○	
Uterine Cancer	○		○		○	
Other Cancers	○	○	○	○	○	○
Depression	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○
High Blood Pressure	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○
Kidney Disease	○	○	○	○	○	○
Osteoporosis	○	○	○	○	○	○
Stroke	○	○	○	○	○	○
Thyroid Disease	○	○	○	○	○	○
Weight Disorders	○	○	○	○	○	○
Seizures	○	○	○	○	○	○
Respiratory Disease	○	○	○	○	○	○
Headaches (Migraine)	○	○	○	○	○	○
Blood Clots	○	○	○	○	○	○
Psychiatric Care	○	○	○	○	○	○
Endometriosis	○		○		○	
Other Medical Problems	○	○	○	○	○	○

please fold on dotted line

SURGICAL HISTORY

Please indicate if you have had any of the following:

○ **I HAVE HAD NO SURGERIES**

- ○ Hysterectomy, Abdominal
- ○ Hysterectomy, Vaginal
- ○ Hysterectomy, Robotic
- ○ Breast Biopsy / Lumpectomy
- ○ Ovaries Removed
- ○ Laparoscopies
- ○ Mastectomy
- ○ Tubal Ligation
- ○ Cesarean Section
- ○ Surgery for Abnormal Pap
- ○ Gallbladder Removed
- ○ Appendectomy
- ○ Colon Surgery
- ○ Bladder Surgery
- ○ Tonsillectomy
- ○ Other Surgeries

SOCIAL HISTORY

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Please describe your current smoking status:

never smoked ○ quit ○ currently smoke (some days) ○ currently smoke (every day) ○

If you smoke(d), how many cigarettes do you (or did you) **smoke per day?**

EXAMPLE
21 cigarettes per day looks like this:

10 20 30
1 2 3

10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

Do you currently use any other tobacco products (e-cigarettes, smokeless tobacco, cigars, etc.)? yes ○ no ○

Are you exposed to secondhand smoke? yes ○ no ○

Do you drink alcohol? yes ○ no ○

Do you or have you ever used drugs? no ○ yes, in the past ○ prefer to discuss with physician ○ yes, currently ○

Do you or a partner have a history of any of the following: yes ○ no ○
IV drug use, multiple blood transfusions, HIV or Hepatitis B

Do you drink caffeine? yes ○ no ○

Do you exercise two or more times per week? yes ○ no ○

Do you feel threatened (physically, emotionally, sexually) **by anyone in your home?** yes ○ no ○