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Direction of Feed

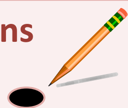
Personal / Family History

Please answer every question

STAFF: Handwritten items must be entered **MANUALLY**.

Marking Instructions

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



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH
Month Day Year

HISTORY OF PRESENT ILLNESS

Patient status: new ◯ established ◯

Person completing form: patient ◯ mother ◯ father ◯ grandparent ◯ friend ◯ other ◯

Referred by: primary care physician ◯ relative / friend ◯ self ◯ other ◯

Reason for visit: annual ◯ GYN problem ◯ infertility consultation ◯ new OB ◯ follow up ◯

Have you ever had a PNEUMONIA VACCINE? yes ◯ no ◯

SOCIAL HISTORY

TOBACCO USE

How would you describe your cigarette smoking? current (every day) ◯ in the past ◯ current (some days) ◯ NEVER ◯

If you smoke now or in the past, please fill in the year you started smoking:
Choose Year: 19 ◯ 20 ◯ — 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9

EXAMPLE
2012 looks like this:
Choose Year 19 20 — 10 20 30 — 1 2 3

If your answer is "in the past", please fill in the year you quit smoking:
Choose Year: 19 ◯ 20 ◯ — 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9

How many cigarettes do you (or did you) **smoke per day?**
10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9

Are you exposed to passive (secondhand) **smoke?** yes ◯ no ◯

ALCOHOL USE

What type(s) of alcohol do you drink? beer ◯ wine ◯ liquor ◯ other ◯

How often do you drink?
Number of times: NEVER ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7+ ◯
Per: NEVER ◯ week ◯ month ◯ year ◯

How many drinks do you have per occasion? 1-2 ◯ 3-5 ◯ 6-9 ◯ 10+ ◯

How often do you have 5 or more drinks per occasion? NEVER ◯ occasionally ◯ rarely ◯ frequently ◯

DRUG USE

prefer to discuss with physician ◯ current ◯ previous ◯ NONE ◯

Type(s): illicit Rx ◯ cocaine ◯ speed ◯ PCP ◯ heroin ◯ marijuana ◯ meth ◯ crack ◯ LSD ◯

RISK FACTORS

Please answer yes or no if you or your partner have had any of the following: yes ◯
IV drug use, multiple blood transfusions, a partner with HIV / Hepatitis B or a partner with any of the aforementioned behaviors. no ◯

CAFFEINE

Type(s) of caffeine: coffee ◯ tea ◯ soft drinks ◯
Drink(s) per day: occasionally ◯ NONE ◯ 1-2 ◯ 3-5 ◯ 6-9 ◯ 10+ ◯

EXERCISE

Type(s) of exercise: bicycling ◯ running ◯ swimming ◯ walking ◯ aerobics ◯ other ◯
Times per week: occasionally ◯ NONE ◯ 1-2 ◯ 3-4 ◯ 5-6 ◯ 7+ ◯

OTHER

Seat belt use (% of time used)**:** 0 ◯ 25 ◯ 50 ◯ 75 ◯ 100 ◯

Sun exposure: rarely ◯ occasionally ◯ frequently ◯

DOMESTIC VIOLENCE

Do you feel safe at home? yes ◯ no ◯

Are you currently being hit, punched, kicked, or slapped by anyone? yes ◯ no ◯

Do you need to discuss violence at home with your health care provider? yes ◯ no ◯

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SAMPLE

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Personal / Family History

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YOUR MEDICAL HISTORY

Please indicate if you have a history of the following. Mark all that apply.

- ○ Colon Cancer
- ○ Breast Cancer
- ○ Lung Cancer
- ○ Ovarian Cancer
- ○ Uterine Cancer
- ○ Other Cancers
- ○ Depression
- ○ Anxiety
- ○ Diabetes
- ○ High Blood Pressure
- ○ Heart Disease
- ○ Kidney Disease
- ○ Osteoporosis
- ○ Osteopenia
- ○ Stroke
- ○ Thyroid Disease
- ○ Eating Disorders
- ○ Seizures
- ○ Epilepsy
- ○ Respiratory Disease
- ○ Headaches (Migraine)
- ○ Blood Clots
- ○ Varicosities
- ○ Psychiatric Hospitalization / Care
- ○ PMS
- ○ Endometriosis
- ○ Bladder Infections
- ○ Uterine Fibroids
- ○ Recurrent Ovarian Cysts
- ○ Anesthesia Complications
- ○ Autoimmune Disorder
- ○ Blood Transfusions
- ○ Rh Factor Sensitization
- ○ Hepatitis
- ○ Liver Disease
- ○ Infertility
- ○ **Other** (please specify): ____________________
- ○ **NO SIGNIFICANT MEDICAL HISTORY**

FAMILY MEDICAL HISTORY

Please indicate which family members have had these illnesses:

	Mother	Father	Sister	Brother	Daughter	Son
Colon Cancer	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○
Lung Cancer	○	○	○	○	○	○
Ovarian Cancer	○		○		○	
Uterine Cancer	○		○		○	
Other Cancer	○	○	○	○	○	○
Anxiety	○	○	○	○	○	○
Depression	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○
High Blood Pressure	○	○	○	○	○	○
Heart Attack	○	○	○	○	○	○
Kidney Disease	○	○	○	○	○	○
Osteoporosis / Osteopenia	○	○	○	○	○	○
Stroke	○	○	○	○	○	○
Thyroid Disease	○	○	○	○	○	○
Eating Disorders	○	○	○	○	○	○
Seizures	○	○	○	○	○	○
Epilepsy	○	○	○	○	○	○
Respiratory Disease	○	○	○	○	○	○
Headaches (Migraine)	○	○	○	○	○	○
Blood Clots	○	○	○	○	○	○
Varicosities	○	○	○	○	○	○
Psychiatric Hospitalization / Care	○	○	○	○	○	○
PMS	○		○		○	
Endometriosis	○		○		○	
Other*	○	○	○	○	○	○

○ **FAMILY HISTORY UNKNOWN**

○ **NO SIGNIFICANT FAMILY MEDICAL HISTORY**

***If you chose 'Other', please specify:**

____

____

____

____

____

____

____

SEXUAL HISTORY

Have you ever had sex?		yes ○	no ○
Are you currently sexually active?		yes ○	no ○
Any problems with sexual functions?		yes ○	no ○
If yes, please explain: ____________________			
Sexual partners:	men ○	women ○	both ○
If you have had sex, did you begin having sex before the age of 18?		yes ○	no ○
Have you had greater than 5 partners in your lifetime?		yes ○	no ○

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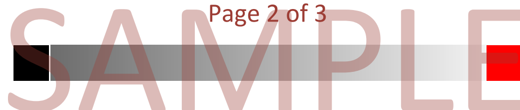

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Personal / Family History

Please answer every question

STAFF: Handwritten items must be entered **MANUALLY**.

Patient's Name: ______________________________

SURGICAL HISTORY

Please indicate if you have had any of the following:

- ◯ **I HAVE HAD NO SURGERIES**
- ◯ **Hysterectomy, Abdominal**
- ◯ **Hysterectomy, Vaginal**
- ◯ **Hysterectomy, Laparoscopic**
  Reason for Hysterectomy: ______________________
- ◯ **Other Laparoscopies**
  Reason for Laparoscopies: ______________________
- ◯ **Colonoscopy**
  ◯ **1-10 years** ◯ **>10 years**
- ◯ Ovary or Ovaries Removed
- ◯ Breast Biopsy
- ◯ Breast Lumpectomy
- ◯ Mastectomy
- ◯ Cosmetic Surgery
- ◯ Tubal Ligation
- ◯ Gallbladder Removal
- ◯ Tonsillectomy
- ◯ Appendectomy
- ◯ Endometrial Ablation

Other Surgeries (please specify):
____
____

GYNECOLOGICAL HISTORY

Menstrual period: light to moderate flow ◯ excessive cramping ◯ excessive flow ◯

Length of flow: 0-4 days ◯ 5-7 days ◯ 8 or more days ◯

Cycle regularity (from 1st day of period to start of next period): regular ◯ irregular ◯ don't have periods ◯

Last pap smear: NONE ◯ less than 1 year ◯ 1-5 years ◯ more than 5 years ◯

Have you had an abnormal pap? yes ◯ no ◯

Have you had cervical dysplasia? yes ◯ no ◯

Last mammogram: NONE ◯ less than 2 years ◯ 2-5 years ◯ more than 5 years ◯

Current contraception (mark all that apply):

◯ abstinence ◯ foam ◯ patch ◯ ring ◯ Nexplanon
◯ condom ◯ hysterectomy ◯ pill ◯ tubal sterilization ◯ other
◯ Depo-Provera© ◯ IUD ◯ rhythm ◯ vasectomy ◯ n/a
◯ NONE

Prior contraception (mark all that apply):

◯ abstinence ◯ foam ◯ patch ◯ ring ◯ other
◯ condom ◯ hysterectomy ◯ pill ◯ tubal sterilization ◯ n/a
◯ Depo-Provera© ◯ IUD ◯ rhythm ◯ vasectomy ◯ NONE

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

If yes, what type(s)? Mark all that apply.
◯ gonorrhea ◯ syphilis ◯ herpes ◯ other
◯ chlamydia ◯ HPV (Human Papillomavirus) ◯ genital warts

PREGNANCY HISTORY

	0	1	2	3	4	5	6	7	8	9	10	11+
Number of pregnancies (include current)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Number of stillbirths		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Number of vaginal deliveries (after 20 weeks)		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Number of premature births (less than 36 weeks)		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Number of ectopic pregnancies (tubal pregnancy)		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Number of miscarriages		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Number of abortions		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Number of C-sections		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Reason for C-sections: Mark all that apply.
◯ breech ◯ failure to progress ◯ fetal distress ◯ other
◯ herpes ◯ repeat C-section ◯ oversized baby

Have you had any pregnancy complications? ◯ yes ◯ no

If yes, please mark all complications:
◯ breech ◯ premature labor ◯ pre-term rupture of membranes
◯ bleeding ◯ high blood pressure ◯ other
◯ diabetes ◯ pre-term delivery ◯ NONE

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

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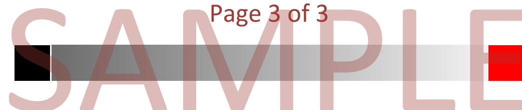

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