Contemporary Women's Care P.A.

Name: ______________________________ Date of Visit:________Date of Birth: __________

Obstetrical History: Please list all pregnancies including miscarriages and abortions.

Date	Route (Vag or C/S)	Sex	Delivery - # Weeks Before/After Due Date	Wt.	Complications

Date	# of Weeks	Miscarriage or Abortion	D & C Required	Complications

Gynecological History:

First day of last period: __________ Age at first period: _____ Length of period: __________

How many days from start of one period to start of next period? ____________________

Flow: Light _____ Medium _____ Heavy _____

Do you pass clots of blood? Yes _____ No _____ If yes, how large? ________________

Cramps? No _____ Mild _____ Moderate _____ Severe _____

Relieved by medication? Yes _____ No _____

What method are you currently using to prevent pregnancy? ________________________________

Have you had?	No	Yes	When
Gonorrhea			
Chlamydia			
Syphilis			
Genital Warts			
Trichomonas			
Herpes			
Hepatitis B			
HIV			

Date of last Pap: __________________ Results: ______________________________

Have you ever had an abnormal pap? Yes _____ No _____ Unsure _____

If yes, when? _________ Results _____________ Treatment Required _______________

Date of last Mammogram: _________________ Results: ____________________________

Date of last Colonoscopy: _________________ Results: ____________________________

Date of last DEXA (bone density) scan: ______________Results: ____________________________

Previous Medical History:

Do you have:	No	Yes	Date of Diagnosis	Treatment
Hypertension				
Diabetes				
Thyroid Disease				
Anemia				
Vitamin D Deficiency				
High Cholesterol				
High Triglycerides				
Heart Disease				
Breast Cancer				
Other Cancer				
Depression/anxiety				
Asthma				
Migraines				
PCOS				
Seasonal allergies				
Osteoporosis				
Other: ______________				

Previous Surgical History: Please list each surgery you have had.

Date	Type	Reason	Surgeon	Complications

Hospitalizations – Other than surgeries and deliveries:

Date	Reason	Physician

List all medications that you are taking regularly: Please include over the counter meds, vitamins, herbs, and supplements.

Medication	Dose	Reason	Prescribed by

List any allergies to medications:

Medication	Reaction

Family History: Please list family members with medical problems.

	Illnesses	Living/Deceased	Age at Death	Cause of Death
Father				
Mother				
Siblings				
______				
______				

Do you have any family history of breast, ovarian, or colon cancer?
No ______ Yes ______ If yes, please list above.

Marital Status: ____________ Sexual Orientation: ____________ Occupation: ______________________
Persons living with you: ____
Do you wear seatbelts? No ___ Yes ___
Do you have an exercise program? No ___ Yes ___ Type ___________ Times/week __________
Do you follow a specific diet? No _____ Yes ______ Type ______________________________
How many servings of dairy do you eat per day? ______________ (8 oz milk, 1 oz cheese, 6 oz yogurt)
Do you smoke now? No _____ Yes _____ PPD _____ For _____ years
Have you smoked in the past? No _____ Yes _____ PPD _____ For _____ years
When did you stop? ______________

How many alcoholic drinks do you have each day? ________ Week ________ Month ________

Do you use: Marijuana _____ Cocaine _____ Heroin _____ Methamphetamines _____ IV Drugs ________
Other ____

Do you perform monthly self breast exams? Yes _________ No __________
Have you been immunized for Hepatitis B? Yes _________ No __________
Have you been immunized for HPV (Gardasil)? Yes _________ No __________
Have you had chicken pox/Varicella vaccination? Yes _________ No __________
Date of last Tetanus booster: ________________
Date of last flu shot: