Name _____ □Miss □Mrs. □Ms. □.Dr
DOB_____ Age_____ Mart Sts: S M D W
Ht: _____ Wt._____ BP _____ T _____P_____ BMI _____

Gynecological History:
Number of Pregnancies _____ _____
Number of Births _____ □Vaginal □ C-section

Contraceptive method:
□ Vasectomy □ Tubal Ligation □ IUD □ Condoms _____
□ Rhythm □ Spermicide □ Depo Provera □ Not Applicable
□ Withdrawal □ Diaphragm □ BC patch/ring/pill □ None

Are your sexual partners? Male Partners□ Female partners□ □Both □None _____

Please fill in the date of your last pap test and whether it was normal or abnormal? _____
Pap Date_____ □Normal □Abnormal _____

Have you ever had an abnormal pap? □No □Yes If yes, what year?_____ _____

Mammogram Date_____ □ Normal □Abnormal □Never Had _____

Dexa Scan (bone density testing) date_____ _____
□Never Had □ Normal □Osteopenia □Osteoporosis _____

Menstrual history:
Last menstrual period :_____(first day of last period) _____
Age when you had your first period_____ _____
Date when you stopped having periods_____ □Not Applicable _____
Menstrual Cycle: Days_____ Duration _____ Clots □Yes □No Painful periods □Yes □No

When was date of last colonoscopy? _____ □Never Had _____

Please list any surgeries:

Year	Procedure	Year	Procedure
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any medical conditions for which you have received treatment including current medical conditions:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Please list all medications you are currently taking:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Risk Summary

Do you have a family history of:
□Heart Attack □Breast Cancer □Uterine Cancer _____
□Heart Disease □Ovarian Cancer □Other Cancer_____ _____
□High Blood Pressure □Diabetes _____

Do you have a medical condition which requires you to take antibiotics at the dentist? □Yes □No _____

Do you have any of the following? _____
□Artificial Joints, if so what joints_____ _____
□Transplants, if so what organs_____ _____
□Mitral valve prolapse _____

Do you have any allergies to any drugs or medications? □No □Yes

If yes, please list drug and type of allergic reaction:

Drug	Reaction	Drug	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Personal History

Have you had the Gardasil Vaccine? No Yes

Have you ever had a sexually transmitted disease or infection? No Yes

Do you have HIV? No Yes

Have you had fewer than 3 normal pap smears in the last 7 years? No Yes

Have you had the Flu Vaccine this year? No Yes

Do you smoke? No Yes # of cigarettes per day____

Number of alcoholic drinks Per day_____ Per week_____

Do you use recreational or illicit drugs No Yes

Are you being abused or have you been abused? No Yes

Do you exercise? Yes No

# of times per week_____

Length of exercise workouts_____

Intensity □Mild □Moderate □High

Review of Systems:

Are you having any problems with?

Weight Loss/Gain	NO	YES	_____	Skin Rashes	NO	YES	_____
Fever	NO	YES	_____	Leg Swelling	NO	YES	_____
Vision	NO	YES	_____	Seizures	NO	YES	_____
Hearing	NO	YES	_____	Headaches	NO	YES	_____
Sore Throat	NO	YES	_____	Depression / Anxiety	NO	YES	_____
Chest Pain	NO	YES	_____	Hot Flashes	NO	YES	_____
Breathing	NO	YES	_____	Bleeding	NO	YES	_____
Coughing	NO	YES	_____	Urination	NO	YES	_____
Stomach Pain	NO	YES	_____	Urine Loss	NO	YES	_____
Joint Pain	NO	YES	_____	Intercourse	NO	YES	_____
Vaginal Discharge	NO	YES	_____	Pelvic Pain	NO	YES	_____
Itching, Burning	NO	YES	_____	Change in Periods	NO	YES	_____
Breast Lump / Discharge	NO	YES	_____	Personal History of HIV	NO	YES	_____

Other:_____

Please list any issues you would like to discuss:

_____

_____

_____

_____

Physician: Dr Pamela Seaman_____Nurse/MA_____Date:_____

FP/IM_____ Consult requested by:_____