

Name:	Date of Birth:	Today's Date:
Occupation:	Marital Status:	Age:
What is the reason you are being seen today?		

1. How old were you when you started having periods? _____
2. What is the date of your last period? _____
3. How many days does your period normally last? ____ How many days between periods? ____
4. Describe your menstrual flow: light moderate heavy Clots? Yes No
5. Are you presently sexually active? Yes No
6. Are you using any form of birth control? Yes No If yes, which method? _____
7. Do you have any pelvic pain? Yes No Pain with intercourse? Yes No
8. Have you ever had a sexually transmitted disease? Yes No
9. If yes , please check and give date of onset: Herpes _____ Genital Warts _____
10. Gonorrhea _____ Syphilis _____ Chlamydia _____ Other _____
11. Do you smoke? Yes No Do you use illicit drugs? Yes No
12. Do you use alcohol? Yes No
13. Are you in a high risk category for HIV? Yes No Have you been tested? Yes No
14. Do you have any urinary problems? Yes No
15. Have you ever been pregnant? Yes No If yes, please list all pregnancies with outcome:

A-abortion			M-Miscarriage			ND-Normal Delivery			CD-Complicated Delivery		
Month/Year	Outcome	Complications		Month/Year	Outcome	Complications		Month/Year	Outcome	Complications	
1				7							
2				8							
3				9							
4				10							
5				11							
6				12							

Dr. Joanne Sansone: Reviewed: Date _____ Updated: Date _____
 Dr. Dominick Giuffrida: Reviewed: Date _____ Updated: Date _____
 Peggy Toth, Nurse Practitioner: Reviewed: Date _____ Updated: Date _____

Mammogram: When? _____ Where? _____
 Chest X-Ray: When? _____ Where? _____
 Pap Smear: When? _____ Where? _____
 HPV: When? _____ Where? _____
 Hemocult: When? _____ Where? _____

Drug Allergies: Please list individually and type of reaction....If none, write none.

Medications: Including prescription, over the counter and vitamin supplements.

Past Medical History: Check all applicable boxes.

- Polio Diabetes Mononucleosis Mental Illness Bronchitis Eczema Psoriasis
- Liver Disease Eye Trouble Pneumonia Hemorrhoids Ear Trouble Ulcers
- Emphysema Hernia Kidney Disease Rheumatic Fever Arthritis Tuberculosis
- Thyroid Disease Depression Heart Disease Mitral Valve Prolapse Other

Surgeries:	Date	Type	Outcome	Where
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____

Family History:

- Cancer Thyroid Allergies High Blood Pressure Epilepsy
- Stroke Heart Disease Mental Illness Other

State of Health: If deceased, give age of death and cause.

Father: _____

Mother: _____

Brother: _____

Sisters: _____

Children: _____