



The American College of Obstetricians and Gynecologists recommend we interview each patient regarding her family, social and medical history. This survey helps identify your risk for cervical and other cancer, as well as chronic diseases such as diabetes and heart disease. If you are uncomfortable answering some of these questions, you may leave them blank.

CONFIDENTIALITY: Your medical records are confidential unless you give us written authorization to release them.

Name \_\_\_\_\_ (nickname): \_\_\_\_\_ D.O.B. \_\_\_\_\_

Reason you are here: \_\_\_\_\_

Do you have an advanced directive? yes no

SOCIAL HISTORY AND HABITS

Marital status: Single Married Divorced Widowed Domestic Partnership

Who lives in your household? \_\_\_\_\_

Do you work outside the home? yes no

Occupation: \_\_\_\_\_

Do you smoke currently? no yes # of cigarettes per day \_\_\_ x # \_\_\_ yrs
Do you drink alcohol? no yes number of drinks per week \_\_\_
Do you use any drugs? no yes if yes, what type? \_\_\_
Do you exercise? no yes type and frequency \_\_\_
Do you consume caffeine? no yes type and frequency \_\_\_

OBSTETRICAL AND GYNECOLOGICAL HISTORY

First day of last period \_\_\_\_\_
Normal flow length \_\_\_\_\_ # of days between periods \_\_\_\_\_
Flow: light moderate heavy

Bleeding between periods yes no
Pain with periods yes no

Are you sexually active? yes no with: men women both
Do you use contraception? yes no Type vasectomy tubal ligation IUD
hormonal (pill, patch, ring)
condoms other \_\_\_\_\_

Have you had problems with any contraception? yes no
Do you have any sexual concerns? yes no
Do you have pain with sex? yes no
New sexual partner in the last year? yes no

Date of last Pap smear \_\_\_\_\_
History of abnormal Pap smears yes no
Treatment for abnormal Pap smears yes no if yes, what? \_\_\_\_\_
History of STDs yes no
If yes, type \_\_\_\_\_

Current medications (Medications name, dose, how often you take it, reason you take it and condition for which you take it)

| medication | diagnosis |
|------------|-----------|
|            |           |
|            |           |
|            |           |

| medication | diagnosis |
|------------|-----------|
|            |           |
|            |           |
|            |           |

Allergies to food/medication and reaction Circle: Latex Tape Iodine

| allergy | reaction |
|---------|----------|
|         |          |
|         |          |
|         |          |

| allergy | reaction |
|---------|----------|
|         |          |
|         |          |
|         |          |

Since your last exam in this office have you had any hospitalizations/surgery/procedures, including office procedures, or been diagnosed with a new medical problem.

\_\_\_\_\_

\_\_\_\_\_

Do you currently or have you had any of the following? (Please circle where appropriate)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Chest pain/palpitation              | <input type="checkbox"/> Difficulty sleeping                | <input type="checkbox"/> Vaginal itching/irritation/discharge  |
| <input type="checkbox"/> Shortness of breath/cough           | <input type="checkbox"/> Any concerning rashes/moles        | <input type="checkbox"/> Breast lumps or pain/nipple discharge |
| <input type="checkbox"/> Heartburn/trouble swallowing/ulcers | <input type="checkbox"/> High Blood Pressure                | <input type="checkbox"/> Depression                            |
| <input type="checkbox"/> Blood in stool/bowel problems       | <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Anxiety/irritability                  |
| <input type="checkbox"/> Weight loss (unexplained)           | <input type="checkbox"/> Vomiting/constipation/diarrhea     | <input type="checkbox"/> Hot flashes/vaginal dryness           |
| <input type="checkbox"/> Visual/hearing problems             | <input type="checkbox"/> Leakage of urine                   | <input type="checkbox"/> Osteoporosis                          |
| <input type="checkbox"/> headaches                           | <input type="checkbox"/> Pain with urination/blood in urine | <input type="checkbox"/> Thyroid problems                      |
| <input type="checkbox"/> Abnormal thirst                     | <input type="checkbox"/> Abnormal bleeding/bruising         | <input type="checkbox"/> Asthma/Emphysema                      |
| <input type="checkbox"/> Joint muscle pain swelling          | <input type="checkbox"/> Leg pain after walking             | <input type="checkbox"/> Cancer (type:)                        |

**FAMILY HISTORY**

Since you first came to this office, has any member of your primary family (mother, father, sister, brother, grandparents, aunts, uncles, etc.) developed breast cancer, ovarian cancer, colon cancer, diabetes or heart disease. Yes No

**SCREENING TEST**

Have you had a tetanus shot in the past 10 years? Yes No  
 Are you immunized for Hepatitis B? Yes No Pnuemonia Yes No Flu Yes No HPV/Gardasil Yes No

**ABUSE SCREEN**

Were you abused as a child? Yes No or as an adult? Yes No  
 In the past year, have you been hit, slapped, kicked or physically hurt by someone? Yes No  
 In the past year, has anyone forced you to have sexual activities? Yes No  
 Do you feel safe where you live? Yes No  
 Are you afraid of someone? Yes No

**HEALTH SCREENING (Have you had the following)**

|             |     |    |              |              |     |    |              |
|-------------|-----|----|--------------|--------------|-----|----|--------------|
| Mammogram   | Yes | No | Date of last | Colonoscopy  | Yes | No | Date of last |
| Cholesterol | Yes | No | _____        | Bone Density | Yes | No | _____        |

Anything else you would like to discuss

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_