



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. _____

Who referred you/ how did you hear about us?: _____

Reason you are here: _____

Do you have an advanced directive? yes no

SOCIAL HISTORY AND HABITS

Age: _____

Marital status: Single Married Divorced Widowed Domestic Partnership

Spouse or partner's name and occupation _____

Who lives in your household? _____

Do you work outside the home? yes no

Occupation: _____

Education: (mark highest level completed)

grade school high school/GED tech school college graduate school

Do you smoke currently? no yes # of cigarettes per day ___ x # ___ yrs
Did you smoke? no yes # of years smoked ___
Do you drink alcohol? no yes number of drinks per week ___
Do you use any drugs? no yes if yes, what type? ___
Any past use of drugs? no yes if yes, what type? ___ Quit date / /
Do you exercise? no yes type and frequency ___
Do you consume caffeine? no yes type and frequency ___

OBSTETRICAL AND GYNECOLOGICAL HISTORY

Age of first period _____

Are you menopausal? yes no Natural or Surgical If yes: Age at menopause _____

any hormone replacement therapy? yes no If yes: For how long? _____

First day of last period _____

Normal flow length _____ # of days between period _____

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 _____

Number of lifetime sexual partners less than 5 5 or more

Age at first intercourse _____

Initials _____ Date _____

Number of pregnancies _____
of vaginal deliveries _____
of cesarean sections _____
of miscarriages _____

of abortions _____
of ectopic pregnancies _____
age at first birth _____

Date of last Pap smear _____
History of abnormal Pap smears yes no
Treatment for abnormal Pap smears yes no
History of STDs yes no

if yes, what? _____

If yes, type _____

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

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

MEDICAL HISTORY - do you currently have any of the following? (Please circle where appropriate)

- | | |
|-----------------------|---------------------|
| High blood pressure | Osteoporosis |
| High cholesterol | Heartburn/ulcer |
| Asthma/emphysema | Bowel problems |
| Thyroid disorder | Depression/anxiety |
| Diabetes | Headaches/migraines |
| Cancer type: _____ | |

Any other medical problems

Please list all surgeries you have had and dates (if you can)

Do you have any concerning symptoms such as? (Please circle where appropriate)

- | | |
|--|---|
| Weight loss/fevers/chills/night sweats | Vaginal/vulvar itching/irritation/discharge |
| Visual/hearing problems/headaches | Abnormal thirst |
| Shortness of breath/cough | Breast lumps or pain/nipple discharge |
| Chest pain/palpitations | Joint/muscle pain or swelling |
| Vomiting/constipation/diarrhea/ | Numbness/tingling/weakness |
| Blood in stool | Depression/anxiety/irritability |
| Heartburn/trouble swallowing | Difficulty sleeping |
| Leakage of urine | Hot flashes/vaginal dryness |
| Pain with urination/blood in urine | Any concerning rashes or moles |
| Abnormal bleeding or bruising | Any food or environmental allergies |
| Leg pain after walking | Other _____ |

FAMILY HISTORY

Family member	age	Health problems	age at death	Cause
Father				
Mother				
Brother or sister				
1)				
2)				
3)				
4)				
5)				
Son or daughter				
1)				
2)				
3)				
4)				
5)				

Do you have any blood relatives who have had: **P** = paternal – father’s side **M** = maternal – mother’s side
 If yes, please indicate who (**M**=mother, **F**=father, **MGM**= maternal grandmother, **PU**= paternal uncle, **MU**= maternal uncle, **PA**= paternal aunt, **MA**= maternal aunt)

	Who?		Who?
Diabetes	_____	Seizure disorder	_____
Cancer	_____	Kidney problems	_____
ovarian	_____	Bowel disorders	_____
breast	_____	Thyroid disorder	_____
colon	_____	High blood pressure	_____
uterine	_____		
Emotional or psychiatric problems	_____		

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)

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

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

Anything else you would like to discuss
