



NAME: _____ Birth date: _____

PROBLEMS YOU WISH TO DISCUSS WITH THE DOCTOR

1
2
3
4
5

ALLERGIES TO MEDICATIONS

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MEDICATIONS YOU ARE CURRENTLY TAKING & WHY

1	3	5	7
2	4	6	8

PREVIOUS SURGERIES

Date	Type of surgery	Date	Type of surgery
1		4	
2		5	
3		6	

PREGNANCIES (include miscarriages abortions or tubal pregnancies)

Date	Weight	Normal/ Forceps/ C-sections	Boy or Girl	Complications

OTHER HOSPITALIZATIONS including ACCIDENTS, ILLNESSES or INJURIES

Date	Reason	Date	Reason

Any Medical Problems Currently being Treated

1	3	5
2	4	6

Rheumatic fever _____ Anemia _____ Hepatitis _____ Epilepsy _____ Diabetes _____ High blood pressure _____ Cancer _____ Migraines _____ Herpes _____ Asthma _____ Tuberculosis _____

Other _____

Date of last period _____ Date last Pap smear _____ Date last mammogram _____ Date last colonoscopy _____

Have you ever had an abnormal pap smear? Yes No

SEXUAL HISTORY

Sexual Preference (please circle) Heterosexual Homosexual Bi-Sexual
 Marital Status: _____ Do you have a new partner? Yes No
 Number of lifetime partners _____ Age of first sexual intercourse _____
 Are you using any method to prevent pregnancy? No _____ Yes _____ If YES which type: Pill _____ Tubal _____ Vasectomy _____ Condoms _____ Depo-Provera _____ Diaphragm _____ Rhythm _____ Other _____
 Do you have pain with intercourse? Yes No
 Are you suffering from low libido? Yes No

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

Uncontrollable loss of urine when you cough or sneeze _____
 Sensation of female organs dropping into the birth canal _____
 Sensation of stool bulging into the birth canal when having a bowel movement _____
 Do you smoke? No _____ Yes _____ cigarettes/day _____
 Do you drink? No _____ Yes _____ how much _____

FAMILY HISTORY

	Yes	No	Which Relative		Yes	No	Which Relative
Breast cancer				Heart disease			
Colon Cancer				High blood pressure			
Ovarian cancer				Kidney disease			
Diabetes				Other			

