Patient name: _____ Date of birth: _____

Identify as: ❑ Female ❑ Male ❑ Other _____

Gynecologic Review of Systems and History:

ALL PATIENTS

Date of last Pap: _____

Past abnormal Pap smear? Yes / No

Have you had DES exposure? Yes / No

Did you receive the HPV vaccine/Gardasil? Yes / No

PRE-MENOPAUSAL PATIENTS ONLY

Age of first period: _____

Date of last period: _____

How long do periods last? _____

Method of birth control used? _____

Are you satisfied with this method? Yes / No

Do you need birth control? _____

Any bleeding between periods? Yes / No

Do you have bleeding during / after sex? Yes / No

POST-MENOPAUSAL PATIENTS ONLY

Do you use hormones? Yes / No

If yes, what kind? _____

Do you have any vaginal bleeding? Yes / No

Age periods stopped? _____

Date of last bone density (if applicable)? _____

PATIENTS AGE 40 AND ABOVE

Date of last mammogram? _____

History of dense breasts (ultrasound for dense breasts)? Yes / No

Date of last colonoscopy (if applicable)? _____

ALL PATIENTS

Past Medical History:

Circle if you have had any of the following.

Arthritis / Joint Pain	Hepatitis / Yellow Jaundice
Asthma	High Blood Pressure
Bladder Infections	Migraine
Blood Transfusions	Migraine with aura
Bowel Trouble	Pneumonia
Cancer	Rheumatic Fever
Chicken Pox	Sexually Transmitted Infections
Chronic Lung Disease	Seizures / Convulsions / Epilepsy
Diabetes	Stroke
Fracture	Thyroid Disease
German measles	Tuberculosis
Glaucoma	Ulcers

Other: _____

Social History:

Occupation: _____

Marital Status (Check one): ❑ Single ❑ Partnered ❑ Married ❑ Widowed ❑ Divorced/Separated

Do you exercise? Yes / No How often? _____ Type: _____

Do you smoke? Yes / No If yes, packs per day for years? _____

If you are a former smoker, when did you quit? _____

Have you ever been sexually abused? Yes / No Have you ever been physically or mentally abused? Yes / No

If yes, would you like to discuss this today? Yes / No Is your current situation safe? Yes / No

Do you get calcium in your diet? Yes / No Supplements taken? _____

Do you drink alcohol? Yes / No If yes, what type of alcohol amount / week _____

Do you use cocaine, heroin, or other drugs not prescribed for you? Yes / No If yes, what kind? _____

Are there any aspects of your past history that was not asked above, that is pertinent to your care? _____

I verify that the above information is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____