



NAME _____ RACE _____ DATE _____
optional)

Who referred you to us? _____

1. Have you ever had a serious illness? i.e. Diabetes, Cancer, High Blood Pressure, etc. _____

2. If cancer, specify type and treatment received _____

3. Any other illnesses or medical problems? i.e. Kidney, Colon, Gall Bladder, etc. _____

4. Have you ever had any surgery? If so, state what type of surgery, the name of your doctor, the date the surgery was performed and at which hospital. _____

5. Are there any serious illnesses that run in your immediate family? _____

6. Are you on any medication (list)? _____
7. Are you allergic to any medications? _____
8. Do you use any tobacco products? _____ What kind? _____ How much? _____
9. Do you drink alcohol? _____ How often? _____
10. Do you use any drugs? _____ How often? _____
11. Have you ever had a sexually transmitted disease? _____ If yes, which one? _____
12. What contraceptives have you used in your lifetime? _____
13. How old were you when you first started your menstrual cycle? _____
14. How many days apart are your periods? i.e. every 28 days _____
15. How many days do your periods last? _____
16. How many pads or tampax do you use on your heaviest days? _____
17. Menstrual cycle cramping: (Circle one) Mild Moderate Severe
18. When was the first day of your last period? _____
19. How many times have you been pregnant? _____
20. How many living children do you have? _____
21. How old is the youngest? _____ Oldest? _____
22. Have you had a mammogram? If so, when? _____
23. When was the date of your last pap smear and the name of the Doctor? _____

24. What is the reason for your visit today? _____
