Patient Name:_____ DOB:_____ Age:_____

GYNECOLOGICAL HISTORY: Any gynecological problems since your last examination? YES or NO
If yes, please explain _____
_____

First day of last menstrual period:_____ Date of last Mammogram:_____
Duration of flow:_____ Date of last Pap Smear:_____
Time between periods:_____ Do you use contraception? _____
Are you sexually active? _____ If yes, type?_____

MEDICAL HISTORY: Any medical problems since your last examination? YES or NO
If yes, please explain _____
_____

Any surgeries/hopitalizations since your last examination? YES or NO
If yes, please explain _____
_____

FAMILY HISTORY: Any changes in your family history since your last examination? YES or NO
(For example, breast cancer, ovarian cancer, uterine cancer and/or colon cancer)
If yes, please explain _____
_____

SOCIAL HISTORY: Any changes in your social history since your last examination? YES or NO
If yes, please explain _____
_____

Marital status: Single Married Separated Divorced Widow Other

Do you exercise regularly? YES or NO
Do you smoke cigarettes? YES or NO If yes, at what age did you start?_____ Packs per day?_____
Do you drink alcohol? YES or NO If yes, amount?_____ How often?_____
Do you use drugs socially? YES or NO If yes, amount?_____ How often?_____
Do you have a living will? YES or NO
Are you a victim of domestic violence or abuse in your present relationship? YES or NO Past Relationships? YES or NO

REVIEW OF SYSTEMS:

Gastrointestinal:
Diarrhea? YES or NO Constipation? YES or NO Other:_____

Genitourinary:
Frequent urination? YES or NO Urinary incontinence? YES or NO Other:_____

Breasts:
Lump/pain? YES or NO Discharge? YES or NO Other:_____

Patient Signature_____ Date:_____