

MENSTRUAL HISTORY

Please complete to the best of your ability and knowledge.

Age at onset of menstruation:				
Date of last menstruation:				
Period every ____ days				
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Number of pregnancies ____ Number of live births ____				
Are you pregnant or breastfeeding now, or did you breastfeed in the past?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any blood in your urine?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any problems with control of urination?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any problems with bowels, such bloody stool, painful movements or urgency?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any hot flashes or sweating at night?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Date of last pap and rectal exam?				

FAMILY HISTORY

Is there a family history of...

Heart Trouble? _____ If so, whom (relationship to you)? _____
Diabetes? _____ If so, whom (relationship to you)? _____
Cancer? _____ If so, of what origin? _____ If so, whom (relationship to you)? _____

MEDICATION LISTING

Please list your prescribed and over-the-counter drugs including supplements, vitamins, inhalers, etc.

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS & PERSONAL SAFETY

AS A REMINDER, ALL QUESTIONS CONTAINED IN THIS DOCUMENT ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex	Are you sexually active?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you trying for a pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Safety	Do you live alone?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physical and/or mental abuse has also become a major public health issue in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?		<input type="checkbox"/> Yes <input type="checkbox"/> No

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you would like to note further detail, please feel free to utilize the space below.

Thank you for taking the time to complete this form in order to facilitate our treatment of your case.