Name: **Date of Birth:** **Date:**

Reason for visit:

Surgical History: Please list all surgeries with dates:

Medication: Are you currently taking any medication(s)? ____Yes ____No

List all medications you are currently taking, including over-the-counter medications, vitamins, and herbal remedies:

Reason for taking current medication(s):

List any allergies to medications: ___No Known Allergies

LATEX Allergy: ___Yes ___No

GYN History:

Date of last period began: _____ How many days does your period last: _____
How often do you have a period: _____

Are you sexually active: ___Yes ___No New Partner: ___ Yes ___No
Sexual Preference: ___Male ___Female ___Both Number of lifetime partners: _____

Method of Birth Control:

___Condom ___ Implanon ___Partner with Vasectomy
___ Pills ___ Vaginal Ring ___ Natural Family Planning
___ Patch ___ Tubal Ligation ___ Other _____
___ IUD ___Depo Provera ___None

Social History:

Do you smoke? ___Yes ___No If "yes" how many packs per day _____ Age you started smoking ____
Do you drink alcoholic beverages? ___Never ___Occasionally ___Frequently
Do you drink caffeinated beverages? ___Never ___Occasionally ___Frequently
Do you use illicit drugs ___Never ___Occasionally ___Frequently If "yes" what type of drug:
Do you exercise? ___Never ___Occasionally ___Frequently _____

Obstetrical History: Please include all pregnancies

Total # Of Pregnancies _____

Delivery Date	Weight of Child(ren)		Delivery Outcome
_____	_____Vaginal	_____ C-section	_____
_____	_____Vaginal	_____ C-section	_____
_____	_____Vaginal	_____ C-section	_____
_____	_____Vaginal	_____ C-section	_____
_____	_____Vaginal	_____ C-section	_____

Total # of miscarriages: _____ Year(s) and weeks' gestation: _____

Full Term pregnancies: _____ D&C: _____ Elective abortion(s): ___Yes ___No

Pre-Term pregnancies: _____ Year(s) and weeks' gestation: _____