Date: ______________ Name: ______________________________ Date of Birth: ______________

Age: ______ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Husband's or partner's name: ______________________ His age: ________

Your occupation: ______________________ His occupation : ______________________

Home phone: ______________________ Work phone: ______________________

I. Medical & Surgical History

- Please list any medication you are taking: ______________________________________

  ____
- Please list any drug allergy: ____

  ____
- Please indicate any significant illness you have had:
  - ☐ High blood pressure ☐ Seizure disorder ☐ Stroke
  - ☐ Heart disease ☐ Mitral valve prolapse ☐ Rheumatic fever
  - ☐ Bleeding problem ☐ Blood clots ☐ Ulcers
  - ☐ Asthma ☐ Thyroid problems ☐ Kidney problems
  - ☐ Hepatitis ☐ Mononucleosis
  - ☐ Other ____
- Past surgeries: Date

1. ____ ____________
2. ____ ____________
3. ____ ____________
4. ____ ____________

- Do you smoke ? _______ How many pack per day ? ______________________________
- Do you use alcohol ? ________ How much per day ? ______________________________
- Do you use recreational drugs (cocaine, marijuana, amphetamine, etc.)? ____________________

II. Menstrual History Your last menstrual period began on ______________

- At what age did you have your first period ? ______________
- Have your periods been irregular over the last 12 months ?... Yes No

  If yes, please describe ____
- Do you have spotting or bleeding between periods ?.. Yes No
- How many days apart are your periods ? ______________
- How many days does your period last ? ______________
- Do you often pass blood clots during your periods ?.. Yes No
- Do you often have painful cramps before or during your periods ?.................................... Yes No
- Do you have pelvic or abdominal pain at other times ? .... Yes No
- At what age did your mother underwent menopause ? ________

III. Sexual History Are you sexually active ?... Yes No

- If yes, how often do you have intercourse ? ______________________
- Do you often have pain with intercourse ? .... Yes No
- How many sexual partners have you had in the past two years ? __________
- Have you ever been diagnosed with a sexually transmitted disease ?... Yes No

  If yes, please mark: ☐ herpes, ☐ chlamydia, ☐ gonorrhea, ☐ venereal warts (condyloma)
- Have you ever had a tubal or pelvic infection ? (not yeast infections)................................... Yes No
- Do you currently have vaginal discharge associated with itching and odor ?................................ Yes No
- Please mark your current method of birth control: ☐Not sexually active; ☐ Unprotected; ☐Rhythm; ☐ Birth Control Pills; ☐ Diaphram/condom/sponge/foam; ☐ IUD ; ☐ Norplant ; ☐ Depo-Provera ; ☐ Tubal ligation; ☐Partner vasectomy; ☐Hysterectomy
- Have you ever had an abnormal pap smear ? .... Yes No

IV. Obstetrical History # of pregnancies: _____ # of children: _____ # miscarriages/abortions _____

Date of Delivery | Type of delivery | Pregnancy Complication

1. ____________________
2. ____________________
3. ____________________
4. ____________________

V. Review of Systems

- How many hours per week do you exercise ? __________
  What type of exercise ? ____________________
- Do you have any significant weight gain or loss over last year ?.. Yes No
  Please describe: ____________________
- Do you frequently feel tired, lack of energy, sleepy, or depressed ? (Please circle) .... Yes No
  Please describe ____________________
- Do you have any discharge from your breast ?.. Yes No
  If yes, from which breast ? _____________, amount _______________, color _______________
- Do you have excessive facial or body hair ? Yes No
- Do you have to shave your face ? How often a week ? _______________ .... Yes No
- Do you have problem with acne ? .... Yes No

VI. Bladder and Bowel Symptoms

- Do you have any problem with urination such as: frequency, pain, or sense of urgency ? (Please circle) Yes No
- Do you leak urine when you exercise or cough ? .... Yes No
- Do you have to wake up to go to bathroom at night ? .... Yes No
  How many times a night ? __________
- Has there been any change in your bowel habits (diarrhea, constipation, irritable stomach)? .... Yes No
- Do you have pain during bowel movement ? .... Yes No
- Do you notice any blood in the stool ?.. Yes No

VII. Family Medical History

Has anyone in your immediate family (mother, father, sister, brother, aunts, uncles, etc.) ever had ...

- Birth defects Who ? ____________________ Yes No
- Genetic diseases Who ? ____________________ Yes No
- Cancer of breast Who ? ____________________ Yes No
- Cancer of uterus or ovary Who ? ____________________ Yes No
- Cancer of colon Who ? ____________________ Yes No
- Diabetes Who ? ____________________ Yes No
- High blood pressure Who ? ____________________ Yes No
- Heart disease Who ? ____________________ Yes No

VIII. Partner's Profile

- Has he fathered any children ? ________ How many ? _______ Age of youngest child ? ______
- Does he have any significant illness (including childhood mumps)?...................................... Yes No
  Please specify ____________________
- Does he take any medication ? ____________________ Yes No
- Has he ever had injury to the groin ? .... Yes No
- Has he ever had male surgery (ie. prostate surgery, vasectomy) ?.. Yes No
- Does he smoke ? ________________ Drink alcohol ? ____________________ Yes No
  Recreational drug ? (marijuana, cocaine, amphetamine, etc) ____________________ Yes No
- Has he had prior exposure to radiation or chemical toxins ? .... Yes No
  Please specify ____________________