Date:____/____/______

Medical History

Name:__________________________ Reason for visit:____________________________

DOB____/____/______ Age:_____

Drug allergies:_________________________

First day of last period____/____/______ Do you have regular monthly periods *Y N*

How often does your period come?_____ How many days does it last?_____

Periods are: ☐ *Mild* ☐ *Moderate* ☐ *Heavy* Cramps are: ☐ *Mild* ☐ *Moderate* ☐ *Severe*

Current birth control method (if any):____________________

Have you had a new sexual partner since last exam? Y N Do you desire testing for STDs? *Y N*

Sexual Partner(s): ☐ *Male* ☐ *Female* ☐ *Both*

Have you ever had a sexually transmitted disease? *Y N* If so, explain_______________

Last Pap smear:_____/_____ Results___________________________________

Have you ever had an abnormal pap smear? *Y N*

If yes, please give year and any procedure(s):__________________________________

Last Mammogram:_____/_____ Results___________________________________

Have you ever had an abnormal mammogram? *Y N*

If yes, please give year and any procedure(s):___________________________________

Do you smoke? *Y N* About_____cigarettes per day

Do you drink alcohol? *Y N* About_____drinks per week

Do you diet? *Y N* What type?_______________

Do you exercise? *Y N* How often and what type?_______________

Do you take calcium? *Y N* If so, how much?_______________

Do you have a primary care physician? *Y N* If so, who?____________________

How did you hear about our practice? ☐ *Ad* ☐ *Internet* ☐ *Previous patient* ☐ *Other*

☐ Referral from:__________________

378 South Branch Rd., Suite 403, Hillsborough, NJ 08844 · (908) 369-0970

Pregnancies **Term_____** **Preterm_____** **Miscarriage_____** **Abortion_____** **Ectopic_____**

Year	Method of Delivery	Gestational age	Sex	Weight	Comments/Complications

Surgery/Hospitalization(s) Date(s)

Medications

Name	Dose	Prescribing Physician

Medical problems

Date of diagnosis	Medical problem	Physician

Personal and Family History (mark all that apply)

Disease	Self	Mother	Father	Maternal GM	Maternal GF	Paternal GM	Paternal GF	Siblings	Other
Breast Cancer									
Blood Clots/Stroke									
Colon Cancer									
Diabetes									
High BP/Heart disease									
Ovarian Cancer									
Osteoporosis									
Thyroid disease									

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