Patient History

Last Name: ____________________ First Name: ____________________ DOB: ________ Today's Date: ________

Menstrual History: Age of First Period			
Age of Menopause		Heavy Periods	[ ] Y [ ] N
Number of Days Between Periods		How Many Days of Heavy Periods?	
Number of Days Periods Last		Painful Periods Irregular Periods	[ ] Y [ ] N [ ] Y [ ] N

Surgical History: **Type:**	**Date:**	**Complications:**

Social / Sexual History:

Social:		**Sexual:**	
Marital Status(if married, date):		Age of First Sexual Intercourse:	
Length of Current Relationship:		History of Child Abuse:	
Do you smoke cigarettes:	[ ] Y [ ] N	Current Method of Birth Control:	
Have you ever been a smoker, even socially?	[ ]Y [ ] N	Current Number of Sexual Partners:	
Do you drink alcohol:	[ ] Y [ ] N	Overall Number of Sexual Partners:	
Do you use illicit drugs:	[ ] Y [ ] N	Sexual Preference (men, women, both):	

Current Medications:
Please list any current prescription medications, over-the-counter medications, hormones, vitamins and herbal supplements you are taking.

Medication, Supplement, etc: (please include strength/dosage)	**Prescribed by:**
1)	
2)	
3)	
4)	
5)	
6)	

Pregnancy/Birth History:

Pregnancy Details		**Delivery Details**	**Year**	**Gender**	**Weight**	**Delivery Mode (Vag/C-Section)**	**Gestational Age (Term, Pre-Term)**	**Complications**
# of Pregnancies:		1st Delivery						
# of Delivers:		2nd Delivery						
# of Ectopic:		3rd Delivery						
# of Miscarriages:		4th Delivery						
# of Abortions:		5th Delivery						
		6th Delivery						

Patient Signature: ______________________________ Today's Date: ____________

Patient's Parent or Legal Guardian Signature: ______________________________ Today's Date: ____________

This is a confidential record and will be kept in your doctor's office. Information contained herein will not be released to anyone without your authorization to do so.