

PLEASE PRINT

Name:		Age:	No. of Pregnancies:	No. of Living Children Now:	
Today's Date:		Current Medications: (inc. herbs, vitamins, and over the counter supplements)			
First day of LMP:					
No. days between periods:					
No. days bleeding:					
Contraception:					
Hormone Replacement Therapy:					
Date of last Pap Smear:					
Any Abnormal Pap Smears?					
Date of last Mammogram:					
Date of last Bone Density:		List any Allergies:			
Date of last Colonoscopy:					
Date of last Bloodwork:					
Past Medical History		Family History: including Grandparents, parents, siblings and children			
Sexually Transmitted Diseases:		Heart Disease			
		Cancer			
		Diabetes			
		Osteoporosis			
		Mental Illness			
Blood Transfusions:		Other			
Serious Illnesses (list):		Health Habits		if yes, how often ?	
		Smoking			
		Alcohol			
		Take vitamins/calcium			
		Exercise regularly			
Surgeries and year done (list):		Do Breast self-exams			
		Relaxation Technique			
Present Health:					
Are you having any problems with:	Yes	No		Yes	No
Menstrual Cramps			Digestion		
Bleeding between periods			Change in bowels habits		
Prolonged periods			Rectal Bleeding		
Pelvic Pain			Urinary Problems		
Bleeding after intercourse			Weight loss/gain		
Pain during intercourse			Sleep Disturbance		
Vaginal Discharge			Headaches		
Breast Lumps			Energy		
Nipple Discharge			Mood Swings		
Menopausal Symptoms			Sexual Problems		
			Marriage/Relationships		