**PLEASE PRINT**

| Name: | Age: | No. of Pregnancies: | No. of Living Children Now: |
|---|---|---|---|

| | **Current Medications:** (inc. herbs, vitamins, and over the counter supplements) |
|---|---|
| Today's Date: | |
| 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 | |
| Blood Transfusions: | Osteoporosis | |
| | Mental Illness | |
| Serious Illnesses (list): | Other | |
| | **Health Habits** | if yes, how often ? |
| | Smoking | |
| | Alcohol | |
| Surgeries and year done (list): | Take vitamins/calcium | |
| | Exercise regularly | |
| | 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 | | | |
| | | | | | | | |