

INITIAL PATIENT DATA

Name: _____ Date: _____

Age: _____ Race: _____ Married () Single () Divorced () Widowed () Committed Relationship ()

Occupation: _____ Name of PCP: _____

Drug Allergies: _____

Date of Last Menstrual Period: _____ Cycles: Regular () Irregular ()

Have you had any abnormal pap smears in the past? Yes () No () If yes when? _____

Surgeries: Year: _____ Description: _____
 Year: _____ Description: _____
 Year: _____ Description: _____

Hospitalizations (other than surgeries):
 Year: _____ Description: _____
 Year: _____ Description: _____

Medications: _____ Dose: _____ How Long? _____
 _____ Dose: _____ How Long? _____
 _____ Dose: _____ How Long? _____

Contraception: _____ How Long? _____

Cigarettes: _____ per day Alcohol: _____ Drug Use: _____

PREGNANICES:		Dur. Of	Type of	Newborn		Complications	
Year	Hospital	Pregnancy	Delivery	Anesthesia	Sex	Wt.	

FAMILY HISTORY:

	Age	Living	Deceased	Health of Cause of Death
Father:				
Mother:				
Siblings:				

CIRCLE IF ANY BLOOD RELATIVE HAS HAD:

Heart Disease	Kidney Disease	Tuberculosis	Mental Disorder
High Blood Pressure	Diabetes	Tumors	Seizures
Hemophilia	Muscular Dystrophy	Mental Retardation	Polycystic Kidney

YOUR PAST MEDICAL HISTORY

	(yes) (no)		(yes) (no)		(yes) (no)
Pelvic Infection	() ()	Diabetes	() ()	Sexually Transmitted Disease	() ()
Mental Disorder	() ()	Thyroid Disease	() ()	Liver or Gall Bladder Disease	() ()
Arthritis	() ()	Heart Disease	() ()	High Blood Pressure	() ()
Rheumatic Fever	() ()	Drugs	() ()	Breast Discharge or Mass	() ()
Varicose Veins	() ()	Phlebitis	() ()	Blood Disorder	() ()
Asthma	() ()	Heart Murmur	() ()	Blood Transfusion	() ()
Pneumonia	() ()	Seizures	() ()	Broken Bones	() ()
Hepatitis	() ()	Kidney Disease	() ()	Sinus Headaches	() ()
Ulcers	() ()	Kidney Infections	() ()	Migraine Headaches	() ()

SIGNATURE: _____