04 - 0704

	Y	N	
1.	☐	☒	Are you allergic to any medications? ☐ Tetracycline ☐ Doxycycline ☐ Penici. ☐ Metal ☐ Aspirin ☐ Iodine ☐ Sulfa ☐ Novocaine ☐ Other _____
2.	☐	☒	Are you taking any prescription or nonprescription drugs? List _____
3.	☐	☒	Are you taking any herbal remedies? List _____
4.	☐	☒	Do you take street drugs? Is so, list _____
5.	☐	☒	Have you ever used IV drugs? If so, when _____ What type _____
6.	☐	☒	Do you smoke cigarettes? If so, # of cigarettes per day _____ How long _____
7.	☐	☒	Do you drink alcohol? If so, # of drinks per day _____ or # of drinks per week _____
8.	☐	☒	Do you consider yourself to have (had) a problem with drugs or alcohol? Please explain _____
9.	☐	☒	Have you ever been hit, slapped, or physically hurt by someone? Who _____
10.	☐	☒	Are you currently sexually active?
11.	☐	☐	If you have intercourse at what age did you begin having intercourse? 18
12.	☐	☐	Number of sex partners in last 6 months? 1 ☒ Male ☐ Female ☐ Both
13.	☐	☐	How often do you use condoms? ☒ Always ☐ Sometimes ☐ Never
14.	☐	☒	Have you ever been forced to engage in sex against your will?
15.	☐	☐	What questions do you have about sex? _____

MEDICAL HISTORY Have you ever had any of the following?

	Y	N		Y	N		Y	N	
1.	☐	☒	Visual problems (not glasses)	13.	☐	☒	Bleeding tendency	25.	☐	☒	High cholesterol/blood fat
2.	☐	☒	Epilepsy (Seizures)	14.	☐	☒	Varicose veins	26.	☐	☒	Obesity
3.	☐	☒	Severe headaches	15.	☐	☒	Cancer _____	27.	☐	☒	Gastro-intestinal disorder
4.	☐	☒	Migraine headaches (MD diagnosed)	16.	☐	☒	Hepatitis/Jaundice	28.	☐	☒	Genito-urinary disorder
5.	☐	☒	Stroke	17.	☐	☒	Gall bladder disease	29.	☐	☒	Breast surgery
6.	☐	☒	Coma	18.	☐	☒	Mononucleosis	30.	☐	☒	Kidney disease/infection
7.	☐	☒	Thyroid disease	19.	☐	☒	Pulmonary embolus (blood clot)	31.	☐	☒	3 or more bladder infection
8.	☐	☒	Breast lump	20.	☐	☒	Pulmonary disease	32.	☐	☒	Blood clots in the legs
9	☒	☐	Asthma	21.	☐	☒	Heart murmur	33.	☐	☒	Suicide attempt
10.	☐	☒	Uterine abnormalities	22.	☐	☒	Heart disease	34.	☐	☒	Severe depression
11.	☐	☒	Diabetes	23.	☐	☒	Mitral valve prolapse	35.	☐	☒	Psychiatric problems
12.	☐	☒	Anemia	24.	☐	☒	High blood pressure	36.	☐	☒	Other major illness

GYNECOLOGICAL HISOTRY Have you had any of the following?

	Y	N		Y	N		Y	N	
37.	☐	☒	Abnormal Pap smear	42.	☐	☒	Infertility	46.	☐	☒	Syphilis
38.	☐	☒	Gynecological surgery or procedure	43.	☐	☒	Frequent vaginal infections	47.	☐	☒	Genital warts
39.	☐	☒	Pelvic tumors/fibroids	44.	☐	☒	Chlamydia	48.	☐	☒	Herpes
40.	☐	☒	Infected tubes or uterus (PID)	45.	☐	☒	Gonorrhea	49.	☐	☒	HIV/AIDS
41.	☐	☒	Date of last Pap smear _____	Result: ☐ Normal ☐ Abnormal							

FAMILY HISTORY Were you adopted? ☒ Y ☐ N If yes, skip this section.

Have your parents, brothers or sisters had any of the following? If yes, who?

Y	N		Who	Y	N		Who
☐	☐	Diabetes	_____	☐	☐	High blood pressure	_____
☐	☐	Stroke	_____	☐	☐	Breast cancer	_____
☐	☐	Heart attack	_____	☐	☐	Cancer of cervix, uterus and or/or ovary	_____
☐	☐	Did either parent die before the age of 50?	_____	☐	☐	Sickle cell/hereditary diseases	_____

☐ ☐ When your mother was pregnant with you did she have any problems?

☐ ☐ Did she take DES to prevent miscarriage?

Patient Signature _____ Date 01/02/03

Staff Signature _____ Date _____

UPDATED 6/00

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