Father _____

Children _____

Siblings_____

Grandmother _____

Grandfather _____

Other _____

Obstetric History: Please list all pregnancies, including miscarriages, terminations, tubal/ectopic pregnancies and deliveries

Date	Type	Weeks	Duration	Weight	Sex	Complications	Living

Type = vaginal/vacuum/forceps/cesarean/miscarriage/D&C/termination/ectopic/tubal
Weeks = how far along when pregnancy ended
Duration = length of labor
Complications = preterm labor, ruptured membranes/water broke, preeclampsia/toxemia etc
Living = (for deliveries only) is child/person still alive

Infertility therapy use: clomid/lupron/injectible therapy/inseminations/IVF/other _____

Gynecologic History

First day of last period _____ Age when your periods started _____ When they stopped_____

Do you have:	Yes	No		Yes	No
Regular periods	☐	☐	Vaginal dryness	☐	☐
Painful periods	☐	☐	Vaginal discharge	☐	☐
Irregular/post menopausal bleeding	☐	☐	Abnormal Pap smears	☐	☐
History of sexually transmitted disease	☐	☐	Abnormal mammograms	☐	☐
Fibroids	☐	☐	Pelvic pain	☐	☐
Ovarian cysts	☐	☐	Decreased libido	☐	☐
Endometriosis	☐	☐	Painful intercourse	☐	☐
Hot flashes	☐	☐	PMS	☐	☐

Age you first had intercourse _____ Lifetime number of partners _____ Currently sexually active: Y / N

Do you use contraception: Y / N What type _____

Date of last Pap smear _____ Result _____

Date of last mammogram _____ Result _____

Date of last Dexa scan _____ Result _____

Do you perform breast self exam? Y / N Do you take calcium? Y / N How many milligrams_____

Please be aware, due to insurance and time constraints, we cannot address specific problems at yearly exam visits.

All information provided will be kept confidential.

Patient Signature _____

Signature of person completing this form (if not patient), and relationship to patient

_____