DOWNTOWN WOMEN OB/GYN ASSOCIATES, LLP

Name:_____ **Today's Date**: _____

How did you hear about our practice? _____

Reason for Today's Visit: Routine Annual Exam: Y N
Issues you would like to discuss: _____

Medications you currently take: _____

Personal Medical History: _____
Current Weight (in lbs):_____ **Current Height** (in ft/in):_____

Are you allergic to any medications? N Y: Medication? _____ If yes, the reaction was: _____

GYN History: Date of last PAP smear: _____
Have you ever had problems with PAPs in past: Y N
If yes, what treatment was needed: _____

Do you menstruate regularly: Y N
First Day of Last Menstrual Period: _____
Age when your periods stopped:_____

OB History: # of Pregnancies you have had: _____

live births: _____ # Miscarriages: _____ # Abortions: _____ #Adoptions: _____

Surgical History: _____

Have you ever been hospitalized for any other reason: N Y; why? _____

Family History: Father: alive Y N; if deceased, at what age____ Health Problems:_____

Mother: alive Y N; if deceased, at what age____ Health Problems: _____

Siblings: alive Y N; if deceased, at what age____ Health Problems:_____

Family History: Breast cancer: Y N Ovarian Cancer: Y N Colon Cancer Y N
If yes, who?_____ If yes, who?_____ If yes, who? _____

Social History: Do you smoke cigarettes: Y N Did you smoke in the past: Y N

How many times per week do you drink alcohol? _____ and how many drinks at a time?_____

Are you currently sexually active: Y N with men with women with both

Do you want to be tested for Sexually Transmitted Infections? Y N

Do you exercise? Y N

What is your current occupation?_____

Do you wear a seatbelt when in a car? Y

Have you ever been the victim of violence? N Y _____