



If any of these questions do not apply to you, please mark those with "N/A".

Name: _____ Age: _____ Date: _____ Last menstrual period _____

When was your last Pap smear? _____	Was it normal?	Yes	No
When was your last Mammogram? _____	Was it normal?	Yes	No
When was your last Colonoscopy? _____	Was it normal?	Yes	No
When was your last Bone Density Test? _____	Was it normal?	Yes	No
When was the last time you had your Cholesterol checked? _____	Was it normal?	Yes	No
Who is your primary care physician? _____			

Are your periods regular (about once a month)? _____
 Are they painful? Yes No Are they heavy? Yes No
 How many days do they last? _____
 Have you gone through menopause? Yes No How old were you? _____
 Have you had bleeding since menopause?

Are you sexually active? Yes No
 What do you use for contraception? _____

Have you ever had (circle): chlamydia gonorrhea syphilis herpes HPV (genital warts)
 Have you ever had an abnormal Pap? Yes No
 If yes, in what year? _____
 If yes, did you have any of the following procedures? (Circle those that apply):

- Colposcopy and biopsy
- Cryosurgery (freezing of the cervix)
- LEEP (minor surgery to remove part of the cervix)
- Cone biopsy (minor surgery to remove part of the cervix)

How many times have you been pregnant? _____ How many vaginal births? _____
 How many C-sections? _____ How many miscarriages? _____ How many abortions? _____
 How many ectopics? _____

Have you completed all or part of the HPV vaccination series? _____ When? _____

Please continue on other side →

Do you have any of the following medical problems? If so, when did symptoms first appear? Please circle and put date.

Diabetes	Osteoporosis	Osteopenia
High Blood Pressure	Glaucoma	Sickle Cell Disease/Trait
High Cholesterol	Hypothyroidism	Migraines
Heart Disease	Hyperthyroidism	Clotting Disorder
Mitral Valve Prolapse	History of Blood Clot in Leg or Lung	
Kidney Disease	Depression	
Asthma	Cancer—What Type? _____	
Arthritis	Other _____	

Have you had (circle):

Vaginal hysterectomy	Abdominal hysterectomy
Supracervical hysterectomy	Laparoscopic assisted hysterectomy
Total laparoscopic hysterectomy	Both ovaries removed

Please list all other operations you have had.

Please list any medications you take regularly (prescription and/or non-prescription). It is not necessary to include dosages.

Please list any drug allergies or enter "none." _____

Please list anyone in your family (parents, siblings, children, grandparents, aunts, uncles, and cousins) with the following diseases:

Diabetes _____

Heart Disease (e.g., heart attacks) _____

High Blood Pressure _____

Osteoporosis _____

Breast Cancer (including age at diagnosis) _____

Ovarian Cancer (including age at diagnosis) _____

Colon Cancer (including age at diagnosis) _____

Blood Clot in the leg _____ Blood Clot in the lung _____

Do you smoke? Yes No If so, how much? _____ How many years? _____

How often do you drink alcohol and how much do you drink? _____

Do you use recreational drugs (e.g., marijuana, cocaine)? _____

Please circle: Single Married Separated Divorced Widowed Other Relationship

What is your occupation? _____

Race: ___ African-American ___ Asian ___ Caucasian ___ Hispanic
___ Native American Indian ___ Other ___ Pacific Islander

Do you exercise regularly? _____ What activity & how many times a week? _____