**COASTAL GYNECOLOGY Morris M. Elstein, MD**

**1744 Sir William Osler Dr Jennifer L. Balderston, MD**

**Virginia Beach, VA 23451 Rita Joyce, NP**

**757-481-4036 FAX# 757-481-5435 Janet Weir, NP**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY & ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ WIDOWED \_\_\_\_\_ DIVORCED \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY NAME/ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRING PHYSICIAN OR REFERRING FRIEND: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER ADRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPOUSE OR PARENT (CIRCLE ONE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SECURE TEXT MESSAGING: YES \_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_

PATIENT PORTAL: YES \_\_\_\_\_\_ NO \_\_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to be added to our **COASTAL 757 AESTHETICS** Email list? YES \_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_

**NEAREST RELATIVE OR NEIGHBOR FOR EMERGENCIES** (NOT LIVING WITH YOU)

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION:**

COMPANY NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY/SUBSCRIBER #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER’S DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

SECONDARY OR SUPPLEMENTAL INSURANCE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY/SUBSCRIBER #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MAIN REASON FOR TODAY’S VISIT**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES:** List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY REACTION

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS:** List all medications you are taking including over-the-counter drugs, vitamins, etc.

NAME DOSE FREQUENCY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medication History Authorization**: Yes \_\_\_\_\_ No \_\_\_\_\_

**IMMUNIZATION HISTORY:** (Most recent date)

Flu shot Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pneumonia Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tdap (Tetanus and pertussis) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gardasil/HPV Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zostavax (Shingles) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shingrix (Shingles) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGICAL HISTORY:**

**SURGERY REASON DATE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY:** (PLEASE CHECK ALL THAT APPLY)

**Y/N NOTES Y/N NOTES**

ADHD \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Genitourinary Disease \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abuse/Domestic Violence \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HIV or AIDS \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anemia \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Headaches \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anesthesia Complications \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hematologic Disease \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiety Disorder \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatic/Liver Disease \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arrhythmia \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Cholesterol \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arthritis \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Blood Pressure \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hypothyroidism \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bipolar \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IBS \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Defects/Disease \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Immunologic Disorder \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Cancer \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Kidney Stones \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Disease \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Menopause \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Migraines \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiovascular Disease \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Multiple Sclerosis \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cerebrovascular (Stroke) \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Musculoskeletal Disease \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colon polyp \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Neurologic Disorder \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coronary Artery Disease \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Obesity \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deep Venous Thrombosis \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Osteoporosis/Osteopenia \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ovarian Cancer \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dermatologic Disorder \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Psychiatric Illness \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes Mellitus \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pulmonary/Lung Disease \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diverticulitis \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Renal/Kidney Disease \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ear or Hearing Disorder \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Seizures/Epilepsy \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eating Disorder \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sleep Apnea \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eczema or Acne \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Substance Abuse/Depen \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Endocrine Disorder \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thrombophilias \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fibromyalgia \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thyroid Disease \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gastroesophageal Reflux \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Urologic Disorder \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gastrointestinal Disease \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vision/Eye Disorder \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Genetic/Hereditary \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vitamin D Deficiency \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:**

Tobacco Smoking Status: Never Smoker:\_\_\_\_\_\_\_ Former Smoker: \_\_\_\_\_\_ Current Smoker: \_\_\_\_\_\_

How Much: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smokeless Tobacco Status: Never used: \_\_\_\_\_ Former Smoker: \_\_\_\_\_ Current Smoker: \_\_\_\_\_

Tobacco years of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Years

E-cigarette/Vape Status: Never used: \_\_\_\_\_ Former User: \_\_\_\_\_ Current user: \_\_\_\_\_\_\_

Alcohol intake: None \_\_\_\_\_\_\_ Occasional \_\_\_\_\_\_\_ Moderate \_\_\_\_\_\_\_ Heavy \_\_\_\_\_\_\_

Advance Directive: Yes \_\_\_\_\_ No \_\_\_\_\_

Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_Separated \_\_\_\_\_Widowed \_\_\_\_\_

Number of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel safe in your current relationship: Yes \_\_\_\_\_ No \_\_\_\_\_

Sexual orientation: Lesbian \_\_\_\_\_\_\_ gay or homosexual \_\_\_\_\_\_\_\_ Straight or Heterosexual \_\_\_\_\_\_\_

Bisexual \_\_\_\_\_ Something else, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you working: Yes \_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational (illicit) Drugs: Yes\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_

**GYN HISTORY:**

Date of LMP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (What was the first day of your last menstrual cycle)

Frequency of cycle \_\_\_\_\_\_\_\_\_\_\_\_\_ Duration of Flow \_\_\_\_\_\_\_\_\_\_

Flow: Light \_\_\_\_\_\_\_\_ Moderate \_\_\_\_\_\_\_\_\_\_\_ Heavy \_\_\_\_\_\_\_\_\_\_\_

Monthly Menses: Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_\_ Menstrual Cramps: Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_

Premenstrual Syndrome: Yes \_\_\_\_\_ No \_\_\_\_\_

Date of Last Pap Smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of HPV Testing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ HPV testing results: Positive \_\_\_\_\_ Negative \_\_\_\_\_

Abnormal Pap: Yes \_\_\_\_\_ No \_\_\_\_\_

Abnormal Pap Smear Results: ASC-US \_\_\_\_\_ ASC-H \_\_\_\_\_ LSIL \_\_\_\_\_ HSIL \_\_\_\_\_ AGC\_\_\_\_\_

Colposcopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any treatment for Abnormal Pap: Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_

Age at menarche (When you first started having periods) \_\_\_\_\_\_\_\_\_\_\_

If post menopausal, age at menopause: \_\_\_\_\_\_\_\_\_\_

Have you had the HPV vaccine series? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

Number of lifetime sexual partners: \_\_\_\_\_\_\_\_ Number of sexual partners in the past 12 months \_\_\_\_\_\_\_

Sexually Active: Yes \_\_\_\_\_ No \_\_\_\_\_ Protected Sex: Always \_\_\_\_\_ Usually \_\_\_\_\_ No \_\_\_\_\_

Sexual Problems: Yes \_\_\_\_\_ No \_\_\_\_\_ Note: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STIs/STDs (Gonorrhea, Chlamydia, Genital Warts, Herpes): Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current birth control method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Desired birth control method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mammogram Results: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Most Recent Bone Density: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Followup years: \_\_\_\_\_\_\_\_\_\_\_\_

Endometriosis: Yes \_\_\_\_\_ No \_\_\_\_\_ Fibroids: Yes \_\_\_\_\_ No \_\_\_\_\_

Infertility: Yes \_\_\_\_\_ No \_\_\_\_\_ Ovarian Cysts: Yes \_\_\_\_\_ No \_\_\_\_\_

PCOS: Yes \_\_\_\_\_ No \_\_\_\_\_

**OB HISTORY:** Total # of Pregnancies: \_\_\_\_\_ Full term: \_\_\_\_\_ Preterm: \_\_\_\_\_ Abortions: \_\_\_\_\_

Miscarriages: \_\_\_\_\_ Ectopics: \_\_\_\_\_ # of Living children: \_\_\_\_\_

**DELIVERY DATES VAGINAL OR C-SECTION BABY’S WEIGHT COMPLICATIONS**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY:**

**RELATION ALIVE? AGE SIGNIFICANT HEALTH PROBLEMS**

**Grandmother** Y/N \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(maternal) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Grandfather** Y/N \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(maternal) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Grandmother** Y/N \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(paternal) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Grandfather** Y/N \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(paternal) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother** Y/N \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Father** Y/N \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Sister**  Y/N \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Brother** Y/N \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_