

Your Health History

- Abnormal PAP or History Of Yes No
- Blood Transfusion/ History Of Yes No
- Blood Clot, DVT, PE/History Of Yes No
- Breast Cancer Yes No
- Breast Disease Yes No
- Bruising/Bleeding Disorder Yes No
- Cervical Cancer Yes No
- DES Exposure Yes No
- Diabetes Yes No
- Diabetes During Pregnancy Yes No
- Endometriosis Yes No
- Hepatitis Type: _____ Yes No
- History of Genital Herpes Yes No
- High Cholesterol Yes No
- Infertility Yes No
- Ovarian Cancer Yes No
- Recurrent Urinary Tract Infections Yes No
- Rheumatic Fever Yes No
- Sexually Transmitted Disease Yes No
- Stroke (CVA) Yes No

Surgical History:

- Augmentation (Breast) Yes No
- Tubal Yes No
- Breast Biopsy Yes No
- Cesarean Section Yes No
- D and C Yes No
- Mastectomy Yes No
- Myomectomy Yes No
- Reduction (Breast) Yes No
- Abdominal
 - Hysterectomy Yes No
 - Ovaries Removed: Yes No
- Vaginal
 - Hysterectomy Yes No
 - Ovaries Removed: Yes No
- Supracervical
 - Hysterectomy Yes No
 - Ovaries Removed: Yes No

Other surgeries you have had:

OTHER: _____

How Are You Today

- | | Pos/Neg | | |
|--|--|---|--|
| Digestive Tract | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had an abdominal pain recently | |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you found blood in your stools recently | |
| | Genital/Urinary Tract | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you experienced the lack of periods recently (amenorrhea) |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you experienced painful periods recently (dysmenorrhea) |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you experienced difficult or painful intercourse recently (dyspareunia) |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you experienced difficult and/or painful urination recently (dysuria) |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had problems with frequent urination recently |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you experienced blood in your urine recently (hematuria) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you experience heavy or excessive bleeding during your periods/menstruation recently (menorrhagia) | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had problems with intense urges to urinate recently | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had problems with being unable to hold your urine before reaching a bathroom (urinary incontinence) | | |
| Skin/Breast | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had problems with vaginal discharge recently | |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had problems with vaginal itching recently | |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you experienced any discharge from your breast(s) recently | |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you found any lumps in your breast(s) recently | |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you experienced any pain in your breast(s) recently | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have problems with abnormal hair growth (hirsutism) | | |

Family History: Please let us know about your family's (Blood Relatives Only: Parents, Siblings, Children) health. Please answer these questions as completely as you can.

- Blood Clotting Disorder Yes No
- Diabetes Yes No
- Heart Disease Yes No
- High Cholesterol Yes No
- High Blood Pressure Yes No
- Stroke Yes No
- Thyroid Disease Yes No

Please indicate whether family members have or have not had the following.	List Family Member	Age of Onset	Age of Death
Breast Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No			
Colon Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No			
Ovarian Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No			

Other: _____

Patient Signature: _____ **Date:** _____