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PATIENT

NAME: _____ AGE: _____ DATE: _____

- 1) Reason for today's visit _____
- 2) First day of last menstrual period. _____ Is your period painful _____
- 3) Age of first menstrual period _____ # of days period lasts _____
- 4) Age you first had intercourse _____ Number of sexual partners _____
- 5) Have you ever been pregnant? _____ Number of pregnancies _____
- 6) Have you ever had any Sexually Transmitted Diseases-if yes explain _____
- 7) Date of last pap smear? _____ Was it a normal result? _____
- 8) Method of Birth Control Used _____
- 9) Current Medical Problems _____
- 10) Have you had any surgery? If yes explain _____
- 11) Allergies to Medications _____
- 12) Are you currently on Medication _____
- 13) Are you in an abusive relationship or do you feel threatened? _____
- 14) Do you smoke? _____

ROS	YES	NO
fever or Weight Loss		
Chest pain		
Shortness of Breath/Asthma		
Changes in Bowel habits		
Blood in urine, leakage of urine, burning with urination		
Allergies, if yes explain		
Depression		
Diabetes, Thyroid		
Easy Bruising, heavy periods		
Do you have any family history of		
Breast Cancer		
Ovarian Cancer		
Heart Attack/Stroke/Disease		
Diabetes		
High Blood Pressure		
Thyroid Disease		