Place Label Here
(office use only)

PATIENT HISTORY

Name ________________________________ Birth Date ______________

Today's Date _____________

1. Reason for visit: ____
   ____
   ____
2. Family History:
   Have any of your immediate relatives (mother, father, siblings, grandparents, spouse) experienced any of the following? *(please indicate which relative)*
   Heart Disease__________ Anemia__________ Breast Cancer ___________
   Osteoporosis__________ Stroke__________ Diabetes__________
   Depression__________ Kidney disease__________
   Cancer__________ Epilepsy__________
   High blood pressure_________ Ulcer__________ Colon Cancer _____________
   Migraine__________ Thyroid disease__________ Arthritis__________
3. Please list any hospitalization, surgeries or major illnesses you have had:________
   ____
4. Have you had any of the following? *(if checked please indicate the date)*
   Depression_______ High blood pressure_______ Arthritis_______
   Liver disease, Hepatitis_______ Lung disease_______ Thyroid disease_______
   Mumps_______ Chicken pox_______ Cancer_______ Asthma _________
   Measles_______ German measles_______ Stroke_______
   Rheumatic fever_______ Dizzy spells_______ Frequent urinary tract infection_______
   Migraines_______ Hayfever/Allergies_______ Diabetes_______ Anemia_______
   Recent weight loss_______ Tuberculosis_______ Scarlet fever_______
5. Please list any medications or herbal supplements you are presently taking
   ____
   ____
6. Please list any known medication allergies ______________________________
   ____
   ____
7. OB/GYN history:
   Date of last menstrual period _______How long do they last? _______ Are they regular? ____
   Do you experience pain with your period? _______________________________
   Date of last Pap smear _______________ Was it normal? ____________________
   Date of last mammogram ____
   Number of pregnancies _______________ Number of live births _______________
   Please list any pregnancy complications ______________________________

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8. Have you ever been diagnosed with a venereal disease (if so, please indicate below)

____

____

9.Do you presently have an abnormal vaginal discharge? If so, please describe.

____

10. Have you ever used an over-the-counter yeast medication (eg. Monistat –7, Mycelex – 7, Gyne-Lotrimin)? Yes No

If yes, when was the last time: ______________________________

Did it relieve your symptoms? ______________________________

11. Do you ever douche? Yes No

If yes, how often? ____________ When did you last douche? ____________

12. What method of birth control do you currently use? ____________

13. Have you ever had vaginal intercourse (sex)? Yes No

Are you sexually active now? Yes No

Have you recently had sex with a new partner? Yes No

Was your last partner male or female? Male Female

Have you ever had intercourse against your will? Yes No

Have you experienced pain with intercourse? Yes No

14. Life style:

Do you smoke? Yes No If yes, how much?

____

Do you drink alcohol? Yes No If yes, how much? ____________

Do you use street drugs? Yes No If yes, what type/how often? ____________

15. Have you experienced emotional change recently? ____________

____

____

16. Have you previously or currently been abused by your partner? Yes No

Please explain ______________________________

____

17. Do you do monthly self-breast exams? Yes No

If no, why? ______________________________

18. Is there anything else you would like to discuss? ____________

____

____