

PREGNANCY HISTORY

30. Could you be pregnant now? Yes _____ No _____
31. Total number of times pregnant _____
32. Number of live births _____
33. Number of living children _____
34. Age of each living child _____
35. Pregnancy Complications? Yes _____ No _____
36. Toxemia? Yes _____ No _____
37. Blood Sugar problems? (diabetes) Yes _____ No _____
38. Birth defects? Yes _____ No _____
39. Cesareans? Yes _____ No _____
40. Number of miscarriages _____
41. Number of stillbirths _____
42. Number of abortions _____
43. Date last pregnancy ended _____
44. How many children would you like? _____
45. Are you planning a pregnancy in the next 2 years?
Yes _____ No _____

CONTRACEPTIVE/GYN/SEXUAL HISTORY

46. Are you sexually active now? Yes _____ No _____
47. What method of birth control do you currently use? _____
48. What methods have you used in the past? _____
49. What method do you wish to use? _____
50. Current or in past
- a) Ovary/Uterus problems Yes _____ No _____
 - b) Infection of uterus/tubes Yes _____ No _____
 - c) Vaginal infection(s) Yes _____ No _____
 - d) Herpes or genital warts Yes _____ No _____
 - e) Gonorrhea, syphilis or chlamydia Yes _____ No _____
 - f) Pain or problems with sex Yes _____ No _____
 - g) Hirsutism (excess hair) Yes _____ No _____
 - h) Breast problems or surgery Yes _____ No _____
51. Age of first sexual intercourse? _____
Having more than one partner increases the chance of infection
52. Have you or your partner had more than one partner in the past 6 months? Yes _____ No _____
53. Are you concerned about a sexually transmitted infection? Yes _____ No _____
54. Do you have sex with: Men _____ Women _____ or Both _____
55. Have any of your partners been bisexual?
Yes _____ No _____

PAP HISTORY

56. Last Pap smear _____
57. Was it normal? Yes _____ No _____
58. Have you ever had follow-up tests for an abnormal pap? Yes _____ No _____

GU-GI HISTORY

- Current or in past
59. Gallbladder disease Yes _____ No _____
60. Kidney infection or problem Yes _____ No _____
61. Bladder infection or problem Yes _____ No _____
62. Stomach or intestine problems Yes _____ No _____

NEURO. HISTORY

- Current or in past
63. Severe or frequent headaches Yes _____ No _____
64. Eyes blurred or distorted vision Yes _____ No _____
65. Emotional problems Yes _____ No _____
(If yes, describe) _____
66. Mental depression Yes _____ No _____
67. Seizures/epilepsy Yes _____ No _____
(If yes, treatment) _____

CARDIOVASCULAR HISTORY

- Current or in past
68. High blood pressure Yes _____ No _____
69. Stroke Yes _____ No _____
70. Heart disease, rheumatic fever Yes _____ No _____
71. Blood clots (thrombophlebitis) Yes _____ No _____
72. Varicose veins Yes _____ No _____
73. Blood disease Yes _____ No _____
74. High cholesterol or triglyceride Yes _____ No _____
75. Sickle Cell Anemia Yes _____ No _____
76. Anemia (Iron) Yes _____ No _____

STAFF COMMENTS

Pregnancy HX: _____

GYN HX: _____

GU-GI HX: _____

NEURO HX: _____

CV HX: _____

Other: _____

Staff Signature

I certify that the answers given are true and complete to the best of my knowledge: (Patient, please sign below)

Name _____ Birthdate _____ Date _____

Reviewed by _____ Clinician Signature