INITIAL PATIENT DATA

Name: ____ Date: ___________________

Age: ______ Race: ________________ Married ( ) Single ( ) Divorced ( ) Widowed ( ) Committed Relationship ( )

Drug Allergies: ____

Date of Last Menstrual Period: ____ Cycles: Regular ( ) Irregular ( )

Have you had any abnormal pap smears in the past? Yes ( ) No ( ) If yes when? ____________________________

Surgeries: Year: __________ Description: ____
Year: __________ Description: ____
Year: __________ Description: ____

Hospitalizations (other than surgeries):
Year: __________ Description: ____
Year: __________ Description: ____

Medications: ________________________________ Dose: ________________ How Long? _________________
________________________________ Dose: ________________ How Long? _________________
________________________________ Dose: ________________ How Long? _________________

Contraception: ____ How Long? __________________

Cigarettes: ____________________per day Alcohol: ________________ Drug Use: ______________

PREGNANICES:

Year	Hospital	City/State	Dur. Of Pregnancy	Type of Delivery	Anesthesia	Newborn Sex Wt.	Complications

FAMILY HISTORY:

	Age	Living	Deceased	Health of Cause of Death
Father:				
Mother:				
Siblings:				

CIRCLE IF ANY BLOOD RELATIVE HAS HAD:

Heart Disease	Kidney Disease	Tuberculosis	Mental Disorder
High Blood Pressure	Diabetes	Tumors	Seizures
Hemophilia	Muscular Dystrophy	Mental Retardation	Polycystic Kidney

YOUR PAST MEDICAL HISTORY

	(yes) (no)		(yes) (no)		(yes) (no)
Pelvic Infection	( ) ( )	Diabetes	( ) ( )	Sexually Transmitted Disease	( ) ( )
Mental Disorder	( ) ( )	Thyroid Disease	( ) ( )	Liver or Gall Bladder Disease	( ) ( )
Arthritis	( ) ( )	Heart Disease	( ) ( )	High Blood Pressure	( ) ( )
Rheumatic Fever	( ) ( )	Drugs	( ) ( )	Breast Discharge or Mass	( ) ( )
Varicose Veins	( ) ( )	Phlebitis	( ) ( )	Blood Disorder	( ) ( )
Asthma	( ) ( )	Heart Murmur	( ) ( )	Blood Transfusion	( ) ( )
Pneumonia	( ) ( )	Seizures	( ) ( )	Broken Bones	( ) ( )
Hepatitis	( ) ( )	Kidney Disease	( ) ( )	Sinus Headaches	( ) ( )
Ulcers	( ) ( )	Kidney Infections	( ) ( )	Migraine Headaches	( ) ( )

SIGNATURE: ____