Patient's Name:_____Date Of Birth:_____
The reason for my visit today is:

_____ Annual health check (Breast and Pelvic Exam and Pap smear if required)

_____ Problem Visit
Nature of Problem_____

Date of last period _____ OR _____No longer have periods

Surgical Information. Please List all surgeries (use space below if needed)

Surgery	Year

Medical Information Please list all medical problems (use space below if needed)

Medical Problem	Year Diagnosed

Pregnancy Information. If applicable, please list number of:

Total Pregnancies	Full Term Deliveries	Preterm Deliveries	Abortions OR Miscarriages	Living Children

- Do you have heavy or painful periods? Yes No
- Do you have frequent loss of urine? Yes No
- Are you interested in a new birth control? Yes No

Genetic Information. Only include children, parents, grandparents, brothers, sisters, aunts, uncles and first cousins.

	Sibling/Children	**Mother's Side**	**Father's Side**
Breast Cancer	Relationship Age	Relationship Age	Relationship Age
Ovarian Cancer	Relationship Age	Relationship Age	Relationship Age
Uterine Cancer	Relationship Age	Relationship Age	Relationship Age
Colon Cancer	Relationship Age	Relationship Age	Relationship Age
Melanoma	Relationship Age	Relationship Age	Relationship Age
Heart Disease	Relationship Age	Relationship Age	Relationship Age
Diabetes	Relationship Age	Relationship Age	Relationship Age
Stroke	Relationship Age	Relationship Age	Relationship Age
Blood Clots	Relationship Age	Relationship Age	Relationship Age

Patient Signature Date

Provider Signature Date