PLEASE COMPLETE ALL 3 PAGES. THANK YOU. CYNTHIA DAVIS, M.D., P.A.

Your name: _____ Age: _____

What is the reason for your visit? _____

_____

_____

_____

Gynecologic History

When and where was your last Pap test? _____
Have you had any abnormal Pap tests? _____
If so, what was the treatment? _____
Did your mother take DES when she was pregnant with you? _____

When and where was your last mammogram? _____
Have you had any abnormal mammograms? _____
Have you had any breast biopsies? _____
Has your mother or sister had breast cancer? _____

Have you had endometriosis? yes no
or uterine fibroids? yes no
or polycystic ovaries? yes no

Have you had a hysterectomy? yes no
If so, what was the reason? _____
Was it vaginal abdominal LAVH?
Were your ovaries removed? yes no don't know

Have you had any other surgery on your reproductive organs? _____
_____

Menstrual History

Questions for women who have not undergone menopause:
Are your periods regular? yes no
How often do you have a period? _____
Describe your flow: light average heavy
Date your last period began: _____
Do you have bleeding in between your periods? yes no
Do you have painful periods? yes no If so, what do you do to relieve the pain? _____

Questions for postmenopausal women:
At what age did you go through menopause? _____
Have you had bleeding since menopause? yes no
If so, when: _____
Do you take estrogen? yes no If so, what is the name and dose?
_____
If you also take progestin, what is the name and dose?
_____

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Pregnancy History

Number of pregnancies you have had: _____
Number of vaginal deliveries:_____ Number of Csections: _____
Number of miscarriages: _____ Number of abortions: _____

Did you have an infection or transfusion with any of the above? _____

Are you trying to become pregnant now? yes no
Do you have a history of infertility? yes no

Contraceptive History

What are you currently using to prevent pregnancy? _____
Have you had problems with any contraceptive method you've used in the past?

Sexual History

Do you have sex? yes no If so, with men or women? _____
Have you had five or more sexual partners in your lifetime? yes no
Do you have more than one partner? yes no
Does your partner have other partners? yes no

Sexual Problems

Do you have pain or bleeding with sex? yes no
Do you have any other sexual problem you would like to discuss?
If so, describe: _____

Vaginal and other Infections

Do you presently have an abnormal vaginal discharge, or itching?

Have you or any of your sexual partners had genital warts, gonorrhea, herpes, chlamydia, syphilis, PID (infection of the tubes and ovaries) or HIV?
If so, describe: _____

Bladder Problems

Do you leak when you cough or sneeze? yes no
Do you leak urine when you have a sudden strong urge? yes no
If so, have you had an evaluation for this? yes no

Other Medical History

Surgery: Please include the appropriate year the surgery was done.

Medical Problems: _____

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Do you smoke? yes no If so, how much? _____packs per day
If you are a former smoker, what year did you quit? _____
Do you drink alcohol? yes no If so, how many drinks per week? _____
Have you ever injected drugs such as heroin or cocaine? yes no

What kind of exercise do you do, and how often? _____
_____
Who is your **primary** doctor? _____
Are there other doctors you see regularly? _____

List your current prescription medications: _____
_____
_____
_____
Do you take any vitamin, mineral, or herbal supplements? If so, list:
_____
Any medications to which you are allergic? _____

Have you ever had any of the following? If so please circle.

Asthma	Gallbladder disease	Seizures
Thyroid disease	Blood clot in a vein	Ulcer
Diverticulitis	Positive test for TB	Hepatitis
Transfusion	Rheumatic Fever	Glaucoma
Migraines	Artificial valve or implant	Fracture

Do you take antibiotics before dental work? yes no

Family History

	ALIVE	DECEASED	HEALTH PROBLEMS
FATHER			
MOTHER			
SISTER			
BROTHER			

Review Of Systems

Circle any symptoms which are bothering you **now**:

General (Constitutional)	Fatique, unexplained change in weight or appetite, hot flashes or night sweats
Cardiovascular	Chest pain or pressure, palpitations or irregular heartbeat
Respiratory	Shortness of breath, cough, wheezing or pain when breathing
Gastrointestinal	Abdominal pain, nausea, vomiting, diarrhea, constipation, or blood in your stools
Genitourinary Female	Abnormal bleeding, pelvic pain, abnormal vaginal discharge, pain with urination or urinary incontinence
Musculoskeletal	Joint pain, stiffness or swelling, back pain, or swelling of the extremities
Neurological	Seizures, headaches, weakness, numbness, paralysis or tremor
Psychiatric	Anxiety, depression or panic attacks
Hematologic/ Lymphatic	Swollen glands in groin or axillae, unusual bleeding or bruising, or anemia
Breasts	New lumps, breast pain or nipple discharge
Endocrine	Goiter, hair loss, new onset of unusual hair growth, heat or cold intolerance