NAME _____ ADDRESS _____

HOME PHONE _____ WORK PHONE _____ MARITAL STATUS _____

OCCUPATION _____ BIRTHDATE _____ ETHNIC ORIGIN _____

INSURANCE _____ REFERRED BY _____

PARTNER'S NAME _____ PARTNER'S OCCUPATION _____

FAMILY HISTORY List anyone in your family (parents, grandparents, or siblings) who has had:

No	Yes	Unsure		No	Yes	Unsure	
☐	☐		Breast Disease _____	☐	☐		High Blood Pressure _____
☐	☐		Cancer _____	☐	☐		Strokes, Blood Clots _____
☐	☐		Diabetes _____	☐	☐		High Cholesterol _____
☐	☐		Heart Disease _____	☐	☐		Sickle Cell Trait/Disease _____
☐	☐		Birth Defects _____	☐	☐		Adopted- Family history unknown

PERSONAL HISTORY Have you ever had:

No	Yes		No	Yes	
☐	☐	Allergy or sensitivity to medication _____	☐	☐	Kidney/Bladder/Urinary Tract Problems _____
☐	☐	High Blood Pressure _____			
☐	☐	Diabetes _____	☐	☐	Liver Disease (Hepatitis, Mono) _____
☐	☐	Cancer _____	☐	☐	Gallbladder Disease _____
☐	☐	Visual Problems _____	☐	☐	Stomach or Bowel Problems _____
☐	☐	Headaches/Migraines/Dizziness _____	☐	☐	Breast Problems _____
☐	☐	Epilepsy/Convulsions/Fainting _____	☐	☐	Vaginal Discharge/Itching _____
☐	☐	Thyroid Disease _____	☐	☐	Sexually Transmitted Diseases:
☐	☐	Hormone Problems _____	☐	☐	Gonorrhea, Syphilis, Chlamydia _____
☐	☐	Lung Problems/TB/Asthma _____	☐	☐	Genital Herpes/Warts _____
☐	☐	Acne _____	☐	☐	Problems with Uterus/Tubes/Ovaries Infection, Ectopic _____
☐	☐	Heart Disease/Murmurs/ Rheumatic Fever _____			_____
☐	☐	Strokes/Clotting Disease _____			
☐	☐	Varicose Veins _____	☐	☐	Abnormal Pap Smear _____
☐	☐	Blood Problems (Anemia, Sickle Cell) _____	☐	☐	Serious illness? _____
☐	☐	High Blood Fats _____	☐	☐	Hospitalization? _____
☐	☐	Fluid Retention (Especially hands/feet) _____	☐	☐	Surgery? Type _____
☐	☐	German measles or Rubella vaccine _____	☐	☐	Psychiatric/Emotional Problems _____
☐	☐	Do you take any medications? _____			_____
☐	☐	Smoking/Alcohol/Drug use? _____	☐	☐	Any relationship involving abuse? _____