PINEVIEW GYNECOLOGY

Name:_____**Nickname**:_____**DOB**:_____

Reason for your visit today: ☐ Annual Well-Woman Exam ☐ Other: _____

Primary Care Physician:_____ **City/State:** _____ **Phone #**_____

GYNECOLOGIC HISTORY:
Last Menstrual Period: _____ Age of First Period:_____ Period every _____days Lasts _____ days
☐ Heavy ☐ Cramps
*Last Pap Smear_____ History of Abnormal Pap: ☐ Yes ☐ No
*Did your mother take the drug DES while she was pregnant with you? ☐ Yes ☐ No
Gardasil/HPV Vaccine_____ Dates:_____

Sexually Active: ☐ Yes ☐ Not Currently ☐ Never ☐ Male Partner ☐ Female Partner
*Did you begin sexual activity before the age of 16? ☐ Yes ☐ No
*Have you had 5 or more sexual partners? ☐ Yes ☐ No
Current Contraception Method: _____ Past Contraceptives:_____

***History of Sexually Transmitted Infections:**
Trichomonas_____ Gonorrhea_____ Chlamydia_____ Genital Warts_____ Syphilis_____ HPV_____ HIV_____
Have you been tested for HIV or Hepatitis?_____

Last Mammogram and Location: _____ Do you do regular Breast Self-Exams: ☐ Yes ☐ No
Hysterectomy: Year _____ Age_____
Age of Menopause: _____
Colonoscopy: ☐ No ☐ Yes-Year/Location/Provider/Results _____
Previous DEXA Bone Density Scan: ☐ No ☐ Yes - Year_____

SOCIAL HISTORY
Do you drink Alcohol? ☐Never ☐Rare ☐Occasional Drinks/week_____
How many times in the last year have you had more than 4 drinks in a day?_____
Do you smoke cigarettes? ☐No ☐Yes Years smoking_____ Packs/day_____ ☐Quit smoking _____ (year)
What is your diet like? _____ Do you exercise regularly? ☐Yes ☐ No
Are you: ☐ Single ☐ Married ☐ Engaged ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with Partner
School Completed: ☐High school ☐College ☐ Graduate Degree ☐Other_____
What is your occupation? _____
Use any illicit drugs? ☐ Yes ☐ No Do you wear your seatbelt? ☐ Yes ☐ No
Do you have Advance Directives in place? (Living Will and/or Medical Power of Attorney) ☐Yes ☐No

Personal Safety:
Has anyone ever threatened to hurt you? ☐ Yes ☐ No
Has anyone ever hit, kicked, choked, or hurt you physically? ☐ Yes ☐ No
Has anyone, including your partner ever forced you to have sex? ☐ Yes ☐ No
Are you ever afraid of your partner? ☐ Yes ☐ No

OBSTETRICAL HISTORY:
Number of Pregnancies: _____ Full-Term Births: _____ Pre-term Births: _____ # of Weeks_____
Miscarriages:_____ Abortions: _____ Ectopic/Tubal Pregnancies:_____ Living Children:_____
C-Section: _____ Vaginal Delivery_____ Complications:_____

Complete Reverse Side

Name: _____ **DOB:** _____

Pharmacy Name/Location: _____ **City/State:** _____

Medications/Dose/Frequency: Include vitamins, herbal, and over the counter medicines

1.	4.
2.	5.
3.	6.

Last Immunization (date):
Flu Shot_____ Pneumonia Vaccine_____

Allergies/Reactions:

1.	3.
2.	4.
☐ **No Known Drug Allergies**	

PAST MEDICAL HISTORY:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease/Heart Failure
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Diabetes
- ☐ Stroke
- ☐ Rheumatic Fever
- ☐ Sleep Apnea
- ☐ GERD/Reflux
- ☐ Diarrhea/Constipation
- ☐ Thyroid Disease
- ☐ Pneumonia
- ☐ Asthma
- ☐ Chronic Lung Disease
- ☐ Kidney Infections/Stones
- ☐ Migraines
- ☐ Depression/Anxiety
- ☐ Ashkenazi Jewish Descent
- ☐ Seizures/Convulsions/Epilepsy
- ☐ Arthritis
- ☐ Cataracts/Macular Degeneration
- ☐ Glaucoma
- ☐ Blood Clots
- ☐ Osteoporosis/Osteopenia
- ☐ Hepatitis/Jaundice
- ☐ Fractures
- ☐ Cancer, Type _____
- ☐ Other _____

SURGICAL HISTORY: Please list all surgeries and biopsies

Date (Year)	Procedure	Date (Year)	Procedure

Have you ever had any problems with Anesthesia? ☐ Yes ☐ No Blood Transfusion? ☐ Yes ☐ No

FAMILY HISTORY:

Disease	Family Relation	Maternal/ Paternal Side	Age Diagnosed	Age of Death
☐ High Blood Pressure				
☐ Diabetes				
☐ Heart Attack				
☐ Heart Disease				
☐ Stroke				
☐ Suicide				
☐ Thyroid Disease				
☐ Drinking Problem				
☐ Blood Clots				
☐ Breast Cancer				
☐ Ovarian Cancer				
☐ Uterine Cancer				
☐ Colon Cancer				
☐ Other Cancer, Type				