Pacific Women's Center
Physicians and Surgeons

Today's Date: ____/____/____ Main reason for visit: _____

Name: _____ **Birth date:** _____ Age: _____ Height: _____

□ Female □ Male □ Transgender (FtM) □ Transgender (MtF) □ Non-binary Preferred pronoun: _____

Primary Care Physician (PCP): _____

Gynecological History:

First day of last normal menstrual period was: ____/____/____ Age of menopause, if applicable: _____

Age of first period: _____ Cramps: □ mild □ moderate □ severe Heavy flow: □ Yes □ No

How long are your menstrual cycles (ie: 28-30 days apart): _____days Average days of flow: _____days

Have you ever had an **abnormal** pap smear? □ Yes □ No when _____ where (City, State) _____

***If yes**: did you have a colposcopy?* □ Yes □ No *Did you have treatment? type:* _____

	Y	N		Y	N
Have you had cervical pre-cancer?			Have you had ovarian cancer?		
Have you had hormone replacement therapy?			Have you ever had a breast biopsy?		
Have you had the HPV/cervical cancer vaccine? (i.e. Gardasil)			Have you had BRCA testing or other genetic cancer screen?		
Did you complete the series (3 injections)?			*If yes, was it:* □ BRCA1+ □ BRCA2+ □ negative		

Are you sexually active □ Yes □ No □ Never

Present Birth Control Method: _____ ***If IUD**: when was it inserted* _____ *where* (City, State) _____

Screening History:

Date of last pap smear: ____/____/____ Date of last colonoscopy: ____/____/____

Date of last mammogram: ____/____/____ Date of last DEXA scan: ____/____/____

Pregnancy History:

Age of first birth _____

Number of: Pregnancies _____ Live Births _____ Miscarriages: *spontaneous* _____ D&C _____

Ectopic Pregnancies _____ Elective Abortions: *medication* _____ D&C _____

Child	DOB	Due Date	Hrs of Labor	C/S or vaginal del	Epidural Y/N	Sex M/F	Weight	Complications	Place of Birth (city, state)	Name of Child
1st										
2nd										
3rd										
4th										

Current Medications: *Please include herbs and/or nutritional supplements*

Medication	Dose	How Often	Medication	Dose	How Often

Allergies: *Please list any allergy you have to medication(s), food(s) and / or other substances*

Medication	Reaction	Medication	Reaction

Surgical History: *Please list surgeries or hospitalizations you have had in chronological order and approximate date.*

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

(OVER) ----------→

Medical History: *Check the appropriate box (and date if past event)*

	current	past		current	past
Anxiety			Chlamydia		
Depression			Gonorrhea		
Other mental health illness			Genital herpes		
Asthma			Genital warts (HPV)		
COPD			Pelvic inflammatory disease		
Sleep Apnea			Pain during intercourse		
Cancer – type			Chronic pelvic pain		
Chronic pain disorder			Uterine fibroids		
Chronic narcotic use			Ovarian cysts		
Diabetes			Frequent vaginal infection		
Eating disorder			Frequent bladder/kidney infection		
Heart disease			Deep vein thrombosis (DVT)		
High blood pressure			Pulmonary embolism (PE)		
High cholesterol			Breast biopsy		
Migraines			IBS		
Osteoporosis/osteopenia			Crohn's disease/Ulcerative colitis		
Seasonal allergies			Sexual abuse		
Seizures			Domestic violence		
Thyroid disorder			OTHER		

Family History: *Check the appropriate box (age of diagnosis if known)*

	Deceased (age)	Breast cancer	Colon cancer	Ovarian cancer	Heart disease	History unknown	High blood pressure	Diabetes	Brain damage	Stroke	Other
Mother											
Father											
Siblings											
Children											
Mom's Dad											
Mom's Mom											
Dad's Dad											
Dad's Mom											
Other											
Are you of Ashkenazi Jewish descent? □ **Yes** □ **No**											

Social History:

Occupation: _____

Do you have a healthy diet? □ Yes □ No Do you exercise? □ Yes □ No Type/frequency: _____

Smoking Status:

□ **Former**	□ **Current**	□ **Never**
Type: □ Cigarettes □ Vape □ Medical marijuana □ Recreational marijuana	*Type:* □ Cigarettes □ Vape □ Medical marijuana □ Recreational marijuana	
How many per day?	*How many per day?*	
When did you quit?		

Alcohol:

□ **Former**	□ **Current**	□ **Never**
How many drinks per week:	*How many drinks per week:*	
When did you quit?		

Recreational Drugs:

□ **Former**	□ **Current**	□ **Never**
Type:	*Type:*	
Amount:	*Amount:*	
When did you quit?		

Relationship Status: □ single □ married □ widowed □ significant other □ same gender □ multiple partners

Spouse/Partner's name: _____ Age: _____

Spouse/Partner's occupation: _____ Start date of current relationship: _____

Do you have other concerns or comments? _____

Name: _____ Birth Date: _____