

**Confidential History**

Name \_\_\_\_\_ Date \_\_\_\_\_

\*\* Please answer each question. All information is kept confidential.

Referred by \_\_\_\_\_

Date of last physical exam \_\_\_\_\_  
 Any abnormal findings \_\_\_\_\_  
 Name of doctor \_\_\_\_\_  
 City and State \_\_\_\_\_  
 Date of last Pap smear \_\_\_\_\_

MENSTRUAL HISTORY

Date of last period \_\_\_\_\_  
 Date of previous period \_\_\_\_\_  
 Was your last period normal                    yes    no  
 Are your periods regular                        yes    no  
 Do you have spotting between periods    yes    no  
 Age at first period \_\_\_\_\_  
 How many days from one period to the next \_\_\_\_\_  
 How long do your periods last \_\_\_\_\_  
 Is your flow:    light    moderate    heavy  
 Are your periods painful                        yes    no  
                   Mild    moderate    severe  
 Do you have other symptoms with your periods  
 If yes, please list \_\_\_\_\_  
 \_\_\_\_\_  
 Have you ever had an abnormal Pap smear  
 If yes, what was the diagnosis \_\_\_\_\_  
 How were you treated \_\_\_\_\_

Is this a routine check-up or are you having problems  
 Please list all current concerns:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

SEXUAL HISTORY

Have you ever been sexually active                    yes    no  
 At what age did you become sexually active \_\_\_\_\_  
 How many sexual partners have you had \_\_\_\_\_  
 Are you currently sexually active                    yes    no  
 Are you using contraception                        yes    no  
 Do you have a history of infertility                    yes    no  
 Do you have bleeding after intercourse            yes    no  
 Do you have pain with intercourse                    yes    no

PREGNANCY HISTORY

How many times have you been pregnant \_\_\_\_\_  
 How many full term deliveries \_\_\_\_\_  
 How many preterm deliveries \_\_\_\_\_  
 How many miscarriages \_\_\_\_\_  
 How many abortions \_\_\_\_\_

PREGNANCY HISTORY

Date of birth	Sex	Weight	Length of labor	Vaginal or cesarean	Complications with pregnancy or delivery

MEDICAL HISTORY – Please circle all illnesses that you have had

Asthma	Cancer	Epilepsy	Kidney Disease
Anemia	Chicken Pox	Heart Disease	Migraines
Arthritis	Depression/Anxiety	Hepatitis	Recurrent Urinary Infections
Bleeding Disorder	Diabetes	Herpes	Sexually Transmitted Disease
Blood Clots	Drug or Alcohol Abuse	High Blood Pressure	Thyroid Disease
Bowel Disease	Eating Disorder	HIV	

Do you have any other illnesses? Please list. \_\_\_\_\_

Have you ever had a blood transfusion?    yes    no  
 If yes, when and what were the circumstances? \_\_\_\_\_

