

Patient Name: _____ Date of Birth: _____

MENARCHE HISTORY:

N/A:

Menses Type: Regular or Irregular Average menses length: _____ days Menses Interval _____ days

When was your last menstrual period? _____

Comment: _____

Age you started your period (Menarche onset): _____

Age you stopped your period (Menopause onset): _____

CONTRACEPTION HISTORY/USE: (Birth control Pill, condoms, IUD, Injection, Patch, Diaphragm, NuvaRing, Implant, etc.)

1. _____ (start) _____ (stop) _____ (why)

2. _____ (start) _____ (stop) _____ (why)

3. _____ (start) _____ (stop) _____ (why)

HABIT/SOCIAL HISTORY

◇ Smoking Status Every day Some Days Former Smoker Never Smoked
 Number of packs per day: _____ Number of years smoking: _____

◇ Alcohol Use Never Occasionally Daily
 Amount per week: _____ Type of alcohol: _____

◇ Drug Use Never Occasionally Daily
 Drug Type: _____ Frequency: _____

◇ Occupation: _____

◇ Highest Level of Education: High School College Graduate Degree

SURGICAL HISTORY-Please check all that apply:

- NONE
- Appendectomy
- Wisdom Teeth
- Breast Enlargement
- Breast Reduction
- Breast Biopsy
- Breast reconstruction
- Hysterectomy
- Ovaries Removed LEFT RIGHT BOTH
- Gall Bladder Removed
- Adenoidectomy
- Tonsillectomy
- C-Section
- Tubal Ligation
- Prostate Removed

DATE/AGE:

FAMILY HISTORY

This applies to 1st and 2nd Generation family members only (i.e.: Mother, Father, Siblings, Paternal Parents, Maternal Parents, Paternal Siblings, Maternal Siblings) Please label which side of family as well. (i.e. Mom's sister is Maternal Aunt) For deceased relatives, please give age at time of death and cause of death.

NONE APPLIES

NOT AWARE OF FAMILY HISTORY

DISEASE OR OTHER MEDICAL CONDITIONS	WHICH FAMILY MEMBER	AGE OF DIAGNOSIS	ALIVE OR DECEASED (If Deceased age at death)
Breast Cancer			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age: _____
Prostate Cancer			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age: _____
Ovarian Cancer			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age: _____
Uterine Cancer			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age: _____
Colon Cancer			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age: _____
Other Cancer:			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age: _____
Heart Disease/Heart Attack			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age: _____
Diabetes			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age: _____
Asthma			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age: _____
Mental illness			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age: _____
High Blood Pressure			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age: _____
Stroke			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age: _____
Kidney Disease			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age: _____
Alcoholism or other Substance abuse			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age: _____

PERSONAL SAFETY –Patient Only (Please check any that apply)

- **Has anyone close to you ever threatened 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 afraid of your partner?** Yes No

MEDICARE “HIGH RISK” CRITERIA – TO BE COMPLETED BY MEDICARE RECIPIENTS ONLY

- **Have you had a pap smear in the last 7 years?** Yes No
- **Have you ever had an abnormal pap smear?** Yes No
- **Did you begin sexual activity before you were 16 years old?** Yes No
- **Have you had more than five (5) sexual partners in your lifetime?** Yes No
- **Have you ever tested positive for the HPV virus?** Yes No
- **Did your mother take the drug DES when she was pregnant with you?** Yes No