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:

_____
_____
_____
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_____
_____

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			☐ Alive ☐Deceased Age:_____
Prostate Cancer			☐ Alive ☐Deceased Age:_____
Ovarian Cancer			☐ Alive ☐Deceased Age:_____
Uterine Cancer			☐ Alive ☐Deceased Age:_____
Colon Cancer			☐ Alive ☐Deceased Age:_____
Other Cancer: _____			☐ Alive ☐Deceased Age:_____
Heart Disease/Heart Attack			☐ Alive ☐Deceased Age:_____
Diabetes			☐ Alive ☐Deceased Age:_____
Asthma			☐ Alive ☐Deceased Age:_____
Mental Illness			☐ Alive ☐Deceased Age:_____
High Blood Pressure			☐ Alive ☐Deceased Age:_____
Stroke			☐ Alive ☐Deceased Age:_____
Kidney Disease			☐ Alive ☐Deceased Age:_____
Alcoholism or other Substance abuse			☐ Alive ☐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**