Name: _____
Birth Date, Age: _____
Birthplace: _____
Occupation: _____
Marital Status: S M DP D W SEP

Race / Ethnicity
☐ Caucasian ☐ Black ☐ Asian ☐ Hispanic/Latino
☐ Other ☐ Refused

Please List Any Major Medical Illnesses:
1. _____
2. _____
3. _____

Please List All Past Surgeries: (What, When)
1. _____
2. _____
3. _____

Please List All Current Medications:
1. _____
2. _____
3. _____

Allergies: _____
Cigarettes _____ packs per day
Alcohol: _____ drinks per week
Drug Use: _____

Please Indicate if you have completed the Gardisil series.
☐ I have not received the Gardisil vaccine.
☐ I have received the Gardisil vaccine. **Please Circle** dose 1 dose 2 dose 3

Menstrual History
Age at Onset: _____
Cycle Length: _____
Duration of Flow: _____
Regular: YES NO
Pain / Cramps: YES NO
1st Day of Last Period _____
Current Birth Control Method:
_____

Pregnancy History
☐ Never Been Pregnant
☐ Have Been Pregnant (List All Pregnancies)

Year	Delivery, Miscarriage or Abortion	Sex	Weight	Complications
____	_____	____	_____	_____
____	_____	____	_____	_____
____	_____	____	_____	_____
____	_____	____	_____	_____
____	_____	____	_____	_____

Past Medical History

	Y	N		Y	N		Y	N
Abnormal Pap Smear	☐	☐	Mitral Valve Prolapse	☐	☐	Bowel Disease	☐	☐
Genital Warts (HPV)	☐	☐	Asthma	☐	☐	Ulcer / Stomach Problems	☐	☐
Gonorrhea	☐	☐	Diabetes	☐	☐	Rectal Bleeding	☐	☐
Syphilis	☐	☐	Thyroid	☐	☐	Kidney Disease	☐	☐
Herpes	☐	☐	Cancer	☐	☐	Kidney Infection / Stones	☐	☐
Chlamydia	☐	☐	High Blood Pressure	☐	☐	Loss of Urine with Cough	☐	☐
Pelvic Inflammatory Disease	☐	☐	Heart Disease / Attack	☐	☐	Fainting Spells	☐	☐
HIV / AIDS	☐	☐	Heart Murmur	☐	☐	Epilepsy / Neurological Disorder	☐	☐
Infertility	☐	☐	Stroke	☐	☐	Migraines / Frequent Headaches	☐	☐
Uterine Anomaly	☐	☐	Chest Pain / Angina	☐	☐	Mental Illness	☐	☐
D.E.S. Exposure	☐	☐	Chronic Cough	☐	☐	Depression	☐	☐
Hepatitis / Liver Disease	☐	☐	Blood clots in Legs/Lungs	☐	☐	Head Injury	☐	☐
Chicken Pox	☐	☐	Swelling of Hands / Feet	☐	☐	Major Accident	☐	☐
Rubella	☐	☐	Anemia	☐	☐	History of Blood Transfusion	☐	☐
Tuberculosis	☐	☐	Skin Disease	☐	☐	Anesthetic Complications	☐	☐
Rheumatic Fever / Lupus	☐	☐	Gall Bladder Disease	☐	☐	Von Willebrand's/Bleeding Disorder	☐	☐

Family History

	Age	Overall Health	Age	Cause of Death
Father	____	_____	____	_____
Mother	____	_____	____	_____
Sibling 1	____	_____	____	_____
Sibling 2	____	_____	____	_____
Sibling 3	____	_____	____	_____
Sibling 4	____	_____	____	_____
Partner	____	_____	____	_____
Child 1	____	_____	____	_____
Child 2	____	_____	____	_____
Child 3	____	_____	____	_____
Child 4	____	_____	____	_____

Please circle then list which relative has had any of the following:
Breast Cancer _____
Ovarian Cancer _____
Uterine Cancer _____
Other Cancer _____
Diabetes _____
Heart Trouble _____
Stroke _____
Epilepsy/Convulsion _____
Tuberculosis _____
Hepatitis _____
Mental Illness _____
Osteoporosis _____