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1223-B MONTAUK HIGHWAY
OAKDALE, NEW YORK 11769

Name_________________________________ **Date of Birth**____/_____/____ **Age**_______ **Date**____________________

Well Woman Update: **(Please provide dates where applicable)**

Last bone density exam ___________________(year)
Last colonoscopy ________________________(year)
Last mammogram_______________________ (year)
Last Pap smear____________________(month/year)

Any abnormal Pap smears? Yes___No____
If yes, any treatment? Dates:
LEEP ___________________________
Cryo ___________________________
Cone Biopsy _____________________
Colposcopy______________________
Other __________________________

Medical History: Do you now have or have you ever had:

□ Anemia
□Asthma
□Autoimmune disorder ________________________
□Anxiety
□Breast tenderness
□Breast discharge
□Bleeding disorder
□Cancer(type?) _______________________
□Chlamydia
□Deep vein thrombosis
□Depression
□Diabetes (type I/type II
□Elevated cholesterol
□Endometriosis
□Excessive weight gain/loss
□Excessive vaginal discharge
□Fibroid (type?)__________
□Frequent UTI
□GERD/Re flux
□G.I. Illness
□Gestational Diabetes
□Gonorrhea
□Heart Disease
□Hepatitis (A, B, C)
□Herpes
□Infertility
□Irritable Bowel Syndrome
□HIV
□HPV
□High blood pressure
□Hyperthyroidism
□Hypothyroidism
□kidney infections
□Liver disease
□Migraines
□Osteopenia
□Osteoporosis
□Pelvic inflamm. Disease
□Seizures
□Syphilis
□Tuberculosis
□Urinary incontinence (leak urine)
□Vaginal dryness
□Vaginitis

Other:____

Surgical History: please list ALL surgical procedures, including year.
____
____
____
____
____

Current Medications________________________________
____
____
Vitamins/Herbal supplements_________________________
Drug Allergies______________________________________

Family History: (please check all applicable)

Illness	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other Relative
Cancer (type)									
Diabetes									
Hypertension									
Heart Disease									
Deep Vein Thrombosis									
Genetic Disorders									
Other									

Reproductive History: Menstrual Cycle
Age at first period? ________If menopausal, age of menopause:__________

How often do you get your menstrual cycle? Every_______days, lasting _______days.

Are your cycles regular? Y/N Do you use □ pads □ tampons

Do you spot between periods? Yes_____No______

Do you have premenstrual symptoms? □bloating □fatigue □depression □irritability

□other________________

Are you sexually active? □ Never □Not currently □ Yes Do you have pain during intercourse? Yes____No____

Method of Contraception

□Not needed	□Vasectomy	□Rhythm method	□IUD(type?)____________________________
□None	□Condoms	□NuvaRing	□Pill (type?)____________________________
	□Patch	□Depo Provera	□Other________________________________

Obstetrical History
Please list all pregnancies, including miscarriages, abortions, and ectopic pregnancies. Please include full birth date.
Type: vaginal, C/S, forceps, or vacuum Anesthesia: epidural, local, general, spinal
Complications: EXAMPLES: preterm labor, diabetes, bleeding, high blood pressure, postpartum depression.
If preterm labor, were medications used?

Birth date	Weeks	Length of labor	Baby's weight	Sex	Type of delivery	Anesthesia	Complications	Location

Social History
Occupation: ____
Are you? □ married □ single □engaged □significant other □ divorced □widowed □same sex partner
Significant others name:________________________________ Phone #________________________________
Other emergency contact name: _________________________Phone# ________________________________

Tobacco Use: □ never □current ______ # of cigarettes a day □ former, quit at age________
Alcohol Use: Y/N *If yes, the average number of drinks per week_________
Do you use street drugs? Y/N *if yes, the type used and last use_______________

How many times and how long per week do you exercise? (circle) 1x 2x 3x 4x 5x+
Per session: 20min. 30 min. 45min. 60+ min.
Do you eat a healthy diet? □ daily □ some days □ no

Any history of violence or abuse in your current household or in your past? Yes______No_______

Do you wish to have a female attendant present during your exam? Yes______ No_____

Patient Signature: ____ Date____________