Today's Date: _____ **NAME:**_____ **BIRTH DATE:**_____ **AGE:** _____	1a. Date of last period: _____ 1b. Age at 1st period: _____ 1c. Age of 1st sex: _____ 1d. How many pregnancies? _____ 1e. How many live births? _____ 1f. How many abortions/miscarriages?____	2a.Desired birth control method **(MARK ONE)** Pills ☐ 3-Month Injection ☐ IUD ☐ Condoms ☐ Other ☐

2b. Current method: Oral ☐ IUD ☐ 3-mo. Injection ☐ Condoms ☐ Diaphragm ☐ Withdrawal ☐ None ☐

FAMILY HISTORY Does anyone in your family have…	**N**	**Y**	If **YES,** please give details
3a. Diabetes?			
b. High Blood Pressure?			
d. Breast Cancer?			
e.Tay Sachs, Down's Syndrome?			
f. Stroke or Heart Attack before age 40?			
PATIENT HISTORY Do you have…….			
4a. Diabetes?			
b. Blood Clots in arms, legs or chest?			
c. Heart Problems/High Blood Pressure?			
d. Anemia/Sickle Cell?			
e. Headaches/Migraines?			
f. Seizures?			
g. Asthma, TB or Lung Problems?			
h. Have you been treated by a doctor for depression?			
i. Breast Mass or Discharge from nipples?			
5a. Vaginal infections or discharge at present?			
b. Abdominal pain?			
c. Any abnormal Pap Smears or female problems?			
d. Sexually transmitted diseases?			
6a. How many days does your period last? _____			
b. Does your period come every month?			
c. Do you have excessive bleeding or pain?			
d. Do you have bleeding between periods or after sex?			
e. Do you engage in Vaginal sex? __ Oral sex? __ Rectal sex? __			
f. Number of sex partners in last year? ____ Female ___ Male____ Length of time with current partner?_____			
7. Do you have any allergies to medications?			
8. Have you had any surgeries, illnesses, or hospitalizations?			
9. Kidney disease or Urinary Tract Infection?			
10. Do you use medication, street drugs, cigarettes, or alcohol?			
11. Do you have Thyroid disease?			
12. Have you been immunized against measles?			
13. History of DES exposure?			
14. Do you see a doctor when you are ill?			

SIGNATURE:	DATE:	Place sticker here