

Today's Date: REASON FOR VISIT: INITIAL EXAM		PREGNANCY HISTORY					INITIAL DATA BASE NAME: _____	
1a. Date of Last Period:		1d. How many Pregnancies?					BIRTHDATE: _____	
1b. Age at 1 st Period:		1e. How many live births?					AGE: _____	
1c. Age of 1 st Sex:		1f. How many abortions?						
SUBJECTIVE DATA BASE		None	Oral	IUD	Diaph	Depo	Other	2b.currentmethod, how long used, problems/ failure
2a. Desired birth control method								
FAMILY HISTORY					N	Y	COMMENTS	
3a. Diabetes								
b. High Blood Pressure								
c. Anemia/Sickle Cell								
d. Breast Cancer								
e. Tay Sachs, Down's Syndrome								
f. Stroke or Heart Attack before age 40								
PATIENT HISTORY								
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? _____ Number female _____ Number Male _____ Length of time with current partner? _____								
7. Do you have any allergies to medications?								
8. List any Surgery, Illness, or Hospitalizations.								
9. Kidney disease/Urinary Tract infection								
10. List any use of medication, street drugs, Cigarettes, or Alcohol.								
11. Do you have thyroid disease?								
12. Have you been immunized against measles?								
13. History of DES exposure?								
PSYCHOSOCIAL/DOMESTIC VIOLENCE								
14. Do you see a Doctor when you are ill?								
15. Is there anyone in your life who is trying to control your actions?								
16. Has anyone at home ever hit you or tried to injure you in any way?								
17. Are you in such a relationship now?								

SIGNATURE:

DATE: