

Provider: Block, Knapp, Seger

Acct #: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age \_\_\_\_\_

**Current Medications-** include vitamins, over-the-counter medications, and herbs

Name	Dose	Frequency

**Current Allergies-**include Eggs, Latex, Peanuts and Shell Fish

Last menstrual period: \_\_\_\_/\_\_\_\_/\_\_\_\_ Postmenopausal Yes No      Number of days of flow: \_\_\_\_  
 Number of days from start of one period to start of next: \_\_\_\_      Heavy flow      Medium flow      Light flow

**Last Pap Smear** \_\_\_\_\_      **Last Mammogram** \_\_\_\_\_      **Last Colonoscopy (If over 50)** \_\_\_\_\_

Sexually Active?    Yes    No

Type of contraceptive:     Pill       Sponge       Depo-Provera       Diaphragm       IUD       Condoms  
 Patch       Ring       Vasectomy       Tubal Ligation       NFP (Natural Family Planning)       None

**Pregnancy History**

Have you had any pregnancies since your last visit?    Yes    No    (including miscarriages and terminations)

**Social History**

Any Changes in employer/occupation? Yes    No    \_\_\_\_\_      Any Changes in marital Status? Yes No \_\_\_\_\_  
 Current Smoker? Yes No    Number of packs per day \_\_\_\_\_

**Family History/Past Surgical History**

Has anyone in your family been diagnosed with a serious illness or died since your last visit?    No    Yes

If yes, explain: \_\_\_\_\_

**Past Surgical History**

Have you had any surgeries since your last visit?    No    Yes    \_\_\_\_\_

Have been hospitalized or diagnosed with an illness? No    Yes    \_\_\_\_\_

**Gynecologic Review of Symptoms-** please check all symptoms that pertain to your health history.

<input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Bleeding after intercourse <input type="checkbox"/> Unpredictable period <input type="checkbox"/> Heavy periods <input type="checkbox"/> Prolonged periods	<input type="checkbox"/> Vaginal/vulvar itching/burning <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Troublesome pelvic pain <input type="checkbox"/> Recent/possible exposure to STD's <input type="checkbox"/> Severe pain with periods	<input type="checkbox"/> Vaginal odor <input type="checkbox"/> Pain with intercourse <input type="checkbox"/> Hot flashes <input type="checkbox"/> Abnormal vaginal discharge
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