Gynecological History (women only):

	Date		Date		Date
Last pap smear	____/____/____	Last mammogram	____/____/____	Last period	____/____/____
Age of 1st period	_____ years	Last bone density	____/____/____	Birth control	Yes No N/A
Are you sexually active?		No 0		Yes 0	

Obstetrical History (women only):

Total number of pregnancies: _____	Total number of live births:_____	Total number of miscarriages:_____	Total number of abortions:_____	Total number of stillbirths:_____	Total number of C-sections;_____

Surgical History:

Please let us know all the surgeries you have had in the past, regardless if they are or not related to the reason for your visit to this office

Date	Type	Reason

Hospitalization History:

Please let us know of recent hospitalizations for diseases or problems that did not require surgery:

Date	Hospital	Reason

Family History:

Please let us know information about your relatives:

Mark here if adopted 0	Status (death or alive)	DOB or present age or age at death	Heath status or serious illnesses
Father			
Mother			

Sisters and Brothers:

Total number	Number alive	DOB or present ages	Serious medical conditions