In accordance with HIPAA privacy requirements, please complete this from and hand it to the nurse when called back – Thank You!

Name: _____ **DOB:** _____
Height: _____ feet _____ inches

Reason for your visit today: _____

1-Medications: (including outside meds, antibiotics, and supplements) _____
_____
_____

2-Drug Allergies (including Latex) _____
_____
_____

3-Reproductive History:

- How old were you when you got your first period? _____ yrs old.
- How often do you get it? (Ex: 28 days) _____
- How many days does it last? (Ex. 7 days) _____
- When was the FIRST day of your last menstrual period? ____/____/____
- Birth Control Method, (if not listed as a medication)? _____

4-Pregnancy Related:

- How many times have you been pregnant? (Including miscarriages or terminations) _____
- How many were delivered full term? (36-40 weeks) _____
- How many terminations? _____ How many miscarriages? _____
- How many were ectopic pregnancies? _____
- How many multiple pregnancies? (ex:1 pregnancy with twins) _____
- How many are living? _____

Please list your pregnancies including dates of any miscarriages or terminations.

	Birthdate	Gestational Age	Male or Female or N/A	Vaginal, Cesarean, VBAC	Miscarriage or Termination
	Ex. 02/12/2011	**40 weeks**	**Female**	**vaginal**	
1			N/A	Choose	
2			N/A	Choose	
3			N/A	Choose	
4			N/A	Choose	
5			N/A	Choose	

5- Have you ever use tobacco products? No

- If yes, do you currently use them? No
- How many tobacco products a day do you use? _____

6-Date of last Pap test: _____ Normal? Yes
7-Date of last Mammogram: _____ Normal? Yes

8-Gardasil (HPV Vaccine)

- Have you ever received the Gardasil Vaccine? Yes
  - If yes, how many doses? _____
  - List the month and year of each doses (at least the year): _____