Stanford HEALTH CARE
STANFORD MEDICINE

Date of Birth:_____/_____/_____

Today's Date:____/____/_____ Your Name:_____

Reason for today's visit:_____

Preferred Pharmacy Name/City:_____ Preferred Lab for testing: _____

MENSTRUAL HISTORY

Date of your last menstrual period_____ Do you have menstrual cramps? □ No □ Yes
What age did you have your first period?_____
Are you post-menopausal □ No □ Yes If yes, at what age?_____
Have you had a hysterectomy? □ No □ Yes If yes, what year?_____ Type_____

Are you sexually active? □ No □ Yes Partner Gender: □ Male □ Female □ Both

CONTRACEPTION

What is your current method of birth control: _____
Are you satisfied with your current method? □ No □ Yes Do you want to change? □ No □ Yes
Are you thinking of conceiving in the next year? □ No □ Yes

GYNECOLOGIC HISTORY

Date of your last Pap Smear_____ Was it normal? □ No □ Yes
Have you ever had an abnormal pap smear? □ No □ Yes What year? _____
Have you ever had a colposcopy for an abnormal pap smear? □ No □ Yes
Have you had treatment for abnormal pap smear? □ No □ Yes, when:_____
Treatment type performed: □ Cryotherapy □ LEEP □ Cone Biopsy

If you are 40 years of age or older, the date of your last Mammogram _____ □ N/A
Have you ever had an abnormal mammogram? □ No □ Yes
Have you ever had breast implants? □ No □ Yes When: □ Current □ Past (removed)
Implant Type: □ Silicone □ Saline
Do you perform regular breast self examinations? □ No □ Yes

If you are 65 years of age or older, the date of your last Dexa/bone scan_____ □ N/A
If you are 50 years of age or older, the date of your last Colonoscopy _____ □ N/A

SOCIAL HISTORY

Tobacco Use: □Never smoked □ Current smoker □ Former smoker Smokeless tobacco use: □ No □ Yes
Do you smoke cigarettes: □ No □ Yes Do you smoke e-cigarettes: □ No □ Yes
If yes,_____amt/day for how long?_____ Ready to quit? □ No □ Yes

Do you drink alcohol: □ No □ Yes If yes, _____drinks □ a day □ a week

Recreational drug use: □ No □ Yes for how long?_____ Former user? □ No □ Yes
Type: □ Marijuana □ Methamphetamine □ Ecstasy □ Heroin □ Cocaine IV □ Prescription Drug
Have you been a victim of abuse or domestic abuse? □ No □ Yes
If you have firearms in your home, are they locked up? □ No □ Yes □ N/A

Today's Date:____/____/_____ Name:_____ Date of Birth:____/____/_____

PREGNANCY HISTORY

How many times have you been pregnant? _____ How many children do you have?_____
How many were deliveries were _____vaginal _____cesarean sections _____VBAC
How many pregnancies were _____miscarriages _____abortions _____ectopic

Month/Year	Birth Weight	Sex	Weeks Pregnant	Type of Birth	Complications

MEDICAL HISTORY- Circle all that apply for past or present conditions □ None

Abnormal Uterine Bleeding
Alcohol Abuse
Alzheimer's
Anemia
Anxiety
Aortic Stenosis
Arthritis
Atrial fibrillation
Asthma
Birth Defects
Cancer Type: _____
Chlamydia
Chronic Obstructive Pulmonary Disease
Congestive heart failure
Coronary artery disease
Dementia
Depression
Diabetes treated with insulin
Diabetes treated with pills
Deep Vein Thrombosis/blood clot
Endometriosis
Fecal Incontinence
Fibroids
Genital warts
Gonorrhea
Heart attack
Herpes
Hepatitis B
Hepatitis C
High blood pressure
High cholesterol
HIV
HPV
Infertility
Irritable Bowel Syndrome
Kidney Problems
Leukemia
Low thyroid
Obesity
Osteoporosis
Obstructive Sleep Apnea
Pain with intercourse
Pelvic Inflammatory disease
Polycystic Ovary Syndrome
Problem with periods
Pulmonary Embolism
Renal Insufficiency or
Recurrent Bladder Infections
Seizure Disorder
Sexual Problems
Sexually Transmitted Disease
Stroke
Syphilis
Tuberculosis
Ulcers or H pylori
Urinary Incontinence
Uterine cramps
Uterine Fibroids
Other:_____

Over the past 2 weeks, how often have you been bothered by any of the following: *(Please circle)*

	Not at all	Several days	More than ½ the days	Nearly every day
1. little interest or pleasure in doing things	0	1	2	3
2. feeling down, depressed or hopeless	0	1	2	3

University HealthCare Alliance ("UHA") is a medical foundation affiliated with Stanford Health Care and Stanford Medicine. UHA contracts with a number of physician groups to provide the medical care in the UHA clinics. Neither UHA, Stanford Health Care, nor Stanford University employ the physicians in the clinics and do not exercise control over the professional services provided by the physician groups.

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FAMILY HISTORY

□ Unknown/Adopted

List any medical conditions that your family has:

Mother:_____

Father:_____

Sister:_____

Sister:_____

Brother:_____

Brother:_____

Any other family member with: *Please state relationship (ex. maternal aunt, paternal grandmother)*

Breast Cancer: _____

Ovarian Cancer:_____

Colon Cancer:_____

SURGICAL HISTORY

□ **None**

	Year		Year		Year
Tonsillectomy		Appendectomy		D&C (miscarriage)	
Cardiac Catherization		Tummy tuck		D&C (bleeding)	
Heart Surgery (CABG)		Gastric bypass		Hysterectomy	
Breast biopsy		Colonoscopy (polyp)		Myomectomy	
Breast implants		laparoscopy		Uterine ablation	
Abdominal Surgery		C-section		LEEP/Cone biopsy	
Hernia repair		Tubal ligation		Other:	

List any drug allergies: □ **None**

Name	Reaction	Name	Reaction

Please list any prescribed medications you are currently taking: □ **None**

Name	Dose	Name	Dose

Please list any non-prescribed/over the counter medications you are currently taking: □ **None**

Name	Name