Date: _____

Name: _____

Date of Birth: ____/____/_____ Age: _____

How do you identify yourself? ☐ Female ☐ Male ☐ Other

Occupation: _____

Name of significant other:_____

Primary Care Physician: _____

Preferred Language:_____

Race: _____ Ethnicity: _____

Referred by: _____

Please check your primary contact:

☐ Home: _____

☐ Work: _____

☐ Mobile: _____

☐ Email: _____

REASON FOR TODAY'S VISIT:

_____

SCREENING TEST AND GYNECOLOGICAL HISTORY

Please list year of most recent test and check if normal or abnormal.

	Date	Normal	Abnormal
Pap Smear:	_____	☐	☐
Colonoscopy:	_____	☐	☐
Mammogram:	_____	☐	☐
Pelvic Sonogram:	_____	☐	☐
Bone Density:	_____	☐	☐

(If abnormal pap, please list type of abnormality: _____)

1. Have you completed the **Gardasil Vaccine Series**? ☐ Yes ☐ No
2. First day of your last menstrual period: _____/_____/_____
3. How old were you when you had your first period? _____/_____/_____

For office use only:

Ht: _____ Wt: _____

BP: _____ Temp: _____

Pap: _____

Mammo: _____

Breast U/S: _____

Pelvic U/S: _____

BD: _____

SEXUAL HISTORY

1. Have you been sexually active within the last year? ☐ Yes ☐ No

(If yes, number of partners within the last year: _____)

2. Sexually active with: ☐ Male ☐ Female ☐ Both
3. Do you use contraception? ☐ Yes ☐ No

If yes, please specify which type of contraception(s) used below:

☐ Condoms	☐ Diaphragm	☐ Essure	☐ Nuvaring
☐ Oral Contraception	☐ Tubes tied	☐ Depo provera shot	
☐ IUD	☐ Vasectomy	☐ Natural family planning	

Please check below if you have had a history of any of the following:

☐ HPV ☐ PID ☐ Gonorrhea ☐ Chlamydia ☐ Herpes ☐ Trichomonas ☐ Syphilis ☐ Hepatitis ☐ None

1. Would you like to be screened for sexually transmitted diseases today? ☐ Yes ☐ No ☐ Unsure
2. Would you like to be screened for Hepatitis C (*recommended if born between 1945-1965*)? ☐ Yes ☐ No ☐ Unsure

Gynecological Concerns (*Check all that apply)*

☐ Irregular periods
☐ Painful periods
☐ PMS
☐ Pain with sex
☐ Hot flashes
☐ Vaginal dryness

Urinary Symptoms (*Check all that apply*)

☐ Burning
☐ Frequency
☐ Blood in urine
☐ Losing urine when coughing/laughing/sneezing
☐ Urgency to urinate
☐ Waking up at night to urinate

PLEASE CONTINUE TO 2ND PAGE

Name: _____ Date of Birth: ____/_____/_____ North Shore LIJ Contemporary Women's Care

OB HISTORY

Total number of pregnancies: _____

Please specify number of pregnancies for each question:

Duration of Pregnancy: Premature: _____ Full-term _____

Outcome of Pregnancy: C-Section _____ Vaginal: _____ **Vaginal birth after C-section:** _____

# of miscarriages: _____ **# of elective terminations:** _____ **# of ectopic pregnancies:** _____

# of currently living children: _____ **# of adopted children:** _____

Twins, triplets or quadruplets? *If yes, please specify*:_____

SURGICAL HISTORY

Please list any other past surgical histories and the dates of each surgery below:

Surgery **Date of Surgery**

_____

_____

_____

PAST MEDICAL HISTORY

Please list all other past medical history and/or conditions below:

_____

_____

1. **Do you have any personal history of blood clotting disorders? ☐ Yes ☐ No If yes, please specify: _____**
2. **Are you willing to accept a blood transfusion in the case of a life threatening situation? ☐ Yes ☐ No**

SOCIAL HISTORY

1. Marital Status: ☐ Married ☐ Common-Law ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Engaged
2. Do you use alcohol? ☐ Never ☐ Occasionally ☐ Routinely
3. Do you use recreational drugs? ☐ Never ☐ Occasionally ☐ Routinely
4. Do you exercise? ☐ Never ☐ Occasionally ☐ Routinely
5. Do you smoke cigarettes? ☐ Never ☐ Occasionally ☐ Routinely

FAMILY HISTORY

Please check all that apply and list the family member (paternal or maternal) that has the condition.

☐ Breast cancer: _____ ☐ Other types of cancer: _____

☐ Ovarian cancer: _____ ☐ Diabetes: _____

☐ Uterine cancer: _____ ☐ High blood pressure: _____

☐ Colon cancer: _____ ☐ Osteoporosis: _____

☐ Blood clotting disorders: _____

Have you or anyone in your family received BRCA Testing? ☐ Yes ☐ No If yes, please specify _____

CURRENT MEDICATIONS

Please list all current medications taken along with the dose taken for each medication. Please include over-the-counter and complementary therapies.

Medication **Dose Taken**

_____ _____

_____ _____

_____ _____

ALLERGIES AND REACTIONS TO MEDICATIONS *Please list below:*

_____

_____

QUESTIONS FOR PHYSICIAN/NURSE PRACTITIONER

_____

PLEASE CONTINUE TO 3RD PAGE

Name: _____ Date of Birth: ____/_____/_____

North Shore LIJ Contemporary Women's Care

PLEASE CHECK ALL THAT CURRENTLY APPLY TO YOU:

Systemic Symptoms
- ☐ Recent change in weight
- ☐ Chills
- ☐ Fever
- ☐ General poor feeling overall
- ☐ None
- ☐ Other: _____

Eye Symptoms
- ☐ Vision problems
- ☐ None
- ☐ Other _____

Ear, Nose and Throat Symptoms
- ☐ Please list any: _____
- ☐ None

Breast Symptoms
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Breast lump
- ☐ None
- ☐ Other: _____

Cardiovascular Symptoms
- ☐ Chest pain or discomfort
- ☐ Fast heart rate
- ☐ Heart palpitations
- ☐ None
- ☐ Other: _____

Musculoskeletal Symptoms
- ☐ Neck pain
- ☐ None
- ☐ Other: _____

Pulmonary Symptoms
- ☐ Please list any: _____

_____
- ☐ None

Gastrointestinal Symptoms
- ☐ Appetite
- ☐ Nausea/ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ None
- ☐ Other: _____

Endocrine Symptoms
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ None
- ☐ Other _____

Neurological Symptoms
- ☐ Dizziness
- ☐ Vertigo
- ☐ Fainting
- ☐ Headaches
- ☐ Motor disturbances
- ☐ Sensory disturbances
- ☐ None
- ☐ Other: _____

Psychological Symptoms
- ☐ Sleep disturbances
- ☐ Anxiety
- ☐ Depression
- ☐ Decrease in sexual interest
- ☐ None
- ☐ Other: _____

Skin Symptoms
- ☐ Excessive itching
- ☐ Skin lesions
- ☐ Rashes
- ☐ None
- ☐ Other: _____

Please list any other symptoms you would like for us to be aware of:

_____

Do you have any interest in the following Laser and Facial Services?

☐ Hair Removal ☐ Vein Therapy ☐ Skin Tightening ☐ Photo Genesis ☐ Microdermabrasion ☐ Chemical Peels

Please return all forms to the front desk when finished. You will be called in shortly.