

NAME _____ AGE _____ DATE ____/____/____

Last menstrual period began on ____/____/____ Was it normal? _____

Are periods regular? _____ How often? _____ Painful? _____ How many days does it last? _____

What medications do you take for menstrual pain? _____

Age at first period? _____ Present method of birth control? _____

What medications do you take? _____

What medications are you allergic to? _____

How much do you smoke? _____ Ounces of alcohol per week? _____

List previous pregnancies, include live births, miscarriages, terminations, etc.

<u>Year</u>	<u>Sex</u>	<u>Infant's Wt.</u>	<u>Complications</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List medical problems from your family history (Cancer, Diabetes, High Blood Pressure, Heart Disease, Stroke, etc.)

Circle if you have had any of the following: **INFORMATION REMAINS CONFIDENTIAL**

- | | | |
|---------------------|------------------------|---------------------------------|
| German Measles | Diabetes | Blood Transfusion |
| Heart Disease | Breast Disease | Epilepsy |
| Lung Disease | Ovarian tumor/cyst | Tumor of the uterus |
| Kidney Disease | Phlebitis/varicosities | Infection of uterus/tubes/ovary |
| Allergies | Blood clots in lungs | Drug/alcohol dependency |
| Migraine Headaches | Hepatitis | Nervous/mental condition |
| High Blood Pressure | Herpes | Thyroid Dysfunction |
| Stroke | Genital Warts | Gonorrhea/Chlamydia/Syphilis |
| Jaundice | + HIV Test | Abnormal Pap Smear |

Explain items circled and list others not mentioned _____

Previous Surgeries _____

When was your last pap smear? ____/____/____ If over 35, Mammogram? ____/____/____

Reason for today's exam? _____

READ BEFORE SIGNING THIS FORM

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits to the party who accepts assignment

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.