NAME: ____ DATE OF BIRTH: ___________ DATE: __________

PERSONAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Occupation: ___________________________________ Years of Education/Highest Degree: _______________
Regular Exercise: ☐Y ☐N What Kind? ____
Are you concerned about your weight? ☐Y ☐N Have you ever had an eating disorder? ☐Y ☐N
Is violence at home a concern? ☐Y ☐N Have you ever been abused? ☐Y ☐N
Do you fall frequently? ☐Y ☐N

Do you use any of the following?	*Now*	*Past*	*Amount/Day and Years of use*
Caffeine	☐Y ☐N	☐Y ☐N	_________________________
Tobacco	☐Y ☐N	☐Y ☐N	_________________________
Alcohol	☐Y ☐N	☐Y ☐N	_________________________
Illicit drugs	☐Y ☐N	☐Y ☐N	_________________________
Recreational drugs	☐Y ☐N	☐Y ☐N	_________________________

MEDICAL HISTORY

Medications prescribed and over-the-counter. Include vitamins, herbs, and home remedies.
☐ See attached list of medications

Medication	Dose (mg)	Directions (How you take)

What local pharmacy do you use? _________________________________ Location ______________________
What mail order pharmacy do you use? ____

Allergies or reactions to medication, food, environment, or other agent.

What are you allergic to?	What reaction or side effect do you have?
Are you allergic to latex? ☐Y ☐N	

St.JosephHealth Medical Group

Name ____________________________________
MRN _____________________________________

Health Problems Past/Current: Check all boxes that apply, listing any pertinent details to include dates and specialists you see for the condition.

	Date	*Specialist*	*Detail*
☐ Neurologic/Stroke/Seizure			
☐ Migraines/Chronic Headaches			
☐ Psychiatric disorder			
☐ Anxiety/Depression			
☐ Post-partum depression			
☐ Thyroid disorder			
☐ Heart disease or murmur			
☐ Hypertension now or in pregnancy			
☐ Asthma/COPD/Emphysema			
☐ Gastrointestinal disorder			
☐ Hepatitis/Liver disease			
☐ Blood disorder/Blood clots			
☐ Blood transfusion			
☐ Is a blood transfusion acceptable?	☐Y ☐N		
☐ Kidney disease			
☐ Autoimmune disorder			
☐ Musculoskeletal disorder			
☐ Diabetes			
☐ Gestational diabetes			
☐ Seasonal allergies			
☐ Uterine fibroids			
☐ Ovarian cysts			
☐ Endometriosis			
☐ Infertility			
☐ Pelvic inflammatory disease			
☐ Hemorrhoids			
☐ Other health problems			

SURGICAL HISTORY

Obstetric Surgery	*Year*	Gynecologic Surgery	*Year*
☐ C-Section		☐ Hysterectomy	
☐ Vacuum/Forceps		☐ D&C	
☐ D&C		☐ Bladder	
☐ Laceration repair		☐ Incontinence	

Other Surgeries	*Year*

Name ______________________________

MRN ______________________________

FAMILY HISTORY ☐ Adopted ☐ Family History Unknown

FAMILY HISTORY *Check all that apply*	Living	Current age or age at death	Mental health disorder	Diabetes	High Blood Pressure	Heart Disease	High Cholesterol	Blood disorders	Other major health problems
Father	☐Y ☐N								
Mother	☐Y ☐N								
Maternal Grandfather	☐Y ☐N								
Maternal Grandmother	☐Y ☐N								
Paternal Grandfather	☐Y ☐N								
Paternal Grandmother	☐Y ☐N								
Siblings	☐Y ☐N								
	☐Y ☐N								
	☐Y ☐N								
Children	☐Y ☐N								
	☐Y ☐N								
	☐Y ☐N								

PERSONAL & FAMILY CANCER HISTORY

Breast & Ovarian Cancer	*Place a check mark in all boxes that apply.*			
	You	Siblings/Children	Mother's Side	Father's Side
Breast Cancer				
Ovarian Cancer				
Breast cancer in both breasts or mult. cancers in same individual				
Male Breast Cancer				
Are you of Ashkenazi Jewish descent?				

Colon/Uterine/Brain/Kidney Cancer	*Place a check mark in all boxes that apply.*			
	You	Siblings/Children	Mother's Side	Father's Side
Uterine (Endometrial) Cancer				
Colon Cancer				
Stomach, Kidney/Urinary, Brain, or Small Bowel Cancer				
10 or more colon polyps found in a lifetime				

Name ____

MRN ____

PERSONAL & FAMILY CANCER HISTORY *(Continued)*

Melanoma & Pancreatic Cancer	*Place a check mark in all boxes that apply.*			
	You	Siblings/Children	Mother's Side	Father's Side
Melanoma				
Pancreatic Cancer				

Other types of Cancer	*Place a check mark in all boxes that apply.*			
	You	Siblings/Children	Mother's Side	Father's Side

We have a Genetic Evaluation & Management Program. If you meet the criteria for referral, would you be interested in receiving Genetic Counseling and/or Cancer Risk Management? ☐Y ☐N

PREGNANCY HISTORY

Please detail your pregnancy history starting with how many total pregnancies and number of each type of pregnancy listed below followed by the particulars of each separate pregnancy (#1, 2, so on) in date order counting miscarriages, molar pregnancies, and abortions as pregnancies.

Total # of pregnancies: # ______		Full term: # ______	Premature: # _______	Abortion: # _______	Miscarriage: # _______	Multi. births: # _______	Ectopic: # ______	Living: # ______
Preg. #	Mo./Yr.	Weeks at delivery	Hours in labor	Baby sex & birth weight	Type of delivery: vaginal or C-section	Anesthesia	Place of delivery	Preterm labor?
#1				M/F				☐Y ☐N
#2				M/F				☐Y ☐N
#3				M/F				☐Y ☐N
#4				M/F				☐Y ☐N
#5				M/F				☐Y ☐N

Comments or Complications: #1 ____

#2 ____

#3 ____

#4 ____

#5 ____

Name ________________________________

MRN ________________________________

GYNECOLOGICAL HISTORY

Pap smear History: Date of last pap _______________ ☐ Normal ☐ Abnormal
Previous abnormal pap ☐Y ☐N
Have you ever had a procedure as a result of an abnormal pap?
☐ Colposcopy ☐Cold knife cone biopsy ☐ LEEP ☐ Cryotherapy/Freezing ☐ Laser

Menstrual History: Age of your first menstrual period _____________
Date of your last menstrual period _____________ ☐ Definite ☐ Approximate
Do you have regular menstrual cycles? ☐Y ☐N
My menstrual cycle comes every ______ days and lasts ______ days.
Menstrual flow ☐ Light ☐ Heavy ☐ Normal
Intensity of cramps ☐ Mild ☐ Medium ☐ Severe

Sexual Health: Are you currently sexually active? ☐Y ☐N
Current # of sexual partners ______ Lifetime # of sexual partners ______
Sexual partner preference ______________________
Age at first intercourse _________
Have you ever had a sexually transmitted infection? ☐Y ☐N
If so, specify what type of infection ____

Have you ever taken hormones other than birth control pills? ☐ Never ☐ Currently ☐ Past
What are you taking or did you take (include name/dose)? ____
Current birth control method if other than pills ____
Previous birth control methods used ____

CURRENT GYNECOLOGICAL CONCERNS

Symptom	Yes	No	Symptom	Yes	No
Breast pain, mass, or lump			Nipple discharge		
Abdominal pain			Indigestion		
Constipation			Diarrhea		
Blood in stool			Blood in urine		
Painful urination			Frequent urination		
Difficulty urinating			Loss of urine (incontinence)		
Painful periods			Abnormal/irregular vaginal bleeding		
Post-menopausal vaginal bleeding			Vaginal dryness		
Hot flashes/Night sweats			Abnormal vaginal discharge		
Sexual dysfunction			Painful intercourse		

Name ______________________________________
MRN ______________________________________