

<p><u>SOCIAL HISTORY & HABITS</u></p> <p>OCCUPATION: _____</p> <p>EMPLOYER: _____</p> <p>Marital status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> w/life partner (male / female)</p> <p>Are you sexually active? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Previously, not now</p> <p>Past/current partner violence? <input type="checkbox"/> No <input type="checkbox"/> Yes _____</p> <p>Do you drink caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____; _____ servings/day</p> <p>Drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Former <input type="checkbox"/> Yes _____ drinks / week</p> <p>Smoke? <input type="checkbox"/> No <input type="checkbox"/> current smoker _____cigs/day for _____ yrs</p> <p><input type="checkbox"/> I am a former smoker _____cigs/day for _____ yrs</p> <p>Do you use other substances? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, (type) _____</p> <p>Do you exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ hrs/ wk</p> <p>Do you use a seatbelt? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p><u>HEALTH SCREENINGS:</u></p> <p>Have you ever had a Pap test? <input type="checkbox"/> No <input type="checkbox"/> Yes Month/year of last? _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal if abnormal, explain _____</p> <p>Have you ever had a mammogram? <input type="checkbox"/> No <input type="checkbox"/> Yes Month/year of last? _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal if abnormal, explain _____</p> <p>Have you ever had a bone density test? <input type="checkbox"/> No <input type="checkbox"/> Yes Year of last? _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal if abnormal, explain _____</p> <p>Have you ever had a colonoscopy? <input type="checkbox"/> No <input type="checkbox"/> Yes Year of last? _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal if abnormal, explain _____</p> <p>Have you ever had a diabetes test? <input type="checkbox"/> No <input type="checkbox"/> Yes Year of last? _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal if abnormal, explain _____</p> <p>Have you ever had a cholesterol test? <input type="checkbox"/> No <input type="checkbox"/> Yes Year of last? _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal if abnormal, explain _____</p>
<p><u>IMMUNIZATIONS:</u> Your physician may ask to have copies of complete immunization records for your chart.</p> <p>Have you been vaccinated for HPV (Gardasil/Cervarix)? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, have you received 1, 2 or all 3 injections of the series? (Please circle) 1 2 3</p>	
<p><u>OBSTETRIC HISTORY</u> <input type="checkbox"/> I HAVE NEVER BEEN PREGNANT</p> <p>Number of pregnancies: _____ Number of living children _____ Vaginal deliveries: _____ Cesarean sections: _____</p> <p>Number of miscarriages: _____ Ectopic (tubal) pregnancies: _____ Abortions : _____ Other losses: _____</p> <p>If you have given birth to at least one child, please enter your age at first live birth _____</p> <p>Please list significant complications you have experienced with pregnancy _____</p> <p>_____</p> <p>_____</p>	

ADDITIONAL SPACE: Use this area if you need more space to complete any section of this form.
