

**Petoskey Gynecology  
& Infertility**

Your Age : \_\_\_\_\_

DATE : \_\_\_\_\_ NAME : \_\_\_\_\_ BIRTHDATE : \_\_\_\_\_

Primary Care Dr. \_\_\_\_\_ Referred here by Dr. \_\_\_\_\_

Reason for this visit : \_\_\_\_\_

Date of Last Menstrual Period : \_\_\_\_\_ Sexually Active? \_\_\_\_\_ Do anything to prevent preg? \_\_\_\_\_  
What? BC Pills \_\_\_\_\_ Patches \_\_\_\_\_ IUD \_\_\_\_\_ Condoms \_\_\_\_\_ Tubal \_\_\_\_\_ Vasectomy \_\_\_\_\_ Other \_\_\_\_\_

Date of Last: Pap smear \_\_\_\_\_ History of abnormal? \_\_\_\_\_  
Mammogram \_\_\_\_\_ History of abnormal? \_\_\_\_\_

Marital Status : Married Single Separated Divorced Widow OCCUPATION : \_\_\_\_\_

Current MEDICATIONS and dosages (incl. Over the counter and herbal): 1 \_\_\_\_\_  
2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_

MEDICATION ALLERGIES : 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_

Other allergies: \_\_\_\_\_

SURGERIES : 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_  
implantable devices: \_\_\_\_\_

OTHER HOSPITALIZATIONS:

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

CURRENT MEDICAL CONDITIONS (PROBLEMS): 1 \_\_\_\_\_ 2 \_\_\_\_\_  
( i.e. diabetes, high blood pressure, arthritis) 3 \_\_\_\_\_ 4 \_\_\_\_\_

Any Mood Disorders(i.e. depression, anxiety): \_\_\_\_\_

OB History : # of pregnancies \_\_\_\_\_ # of deliveries \_\_\_\_\_ Children's ages: \_\_\_\_\_

WHO IN THE FAMILY HAS (HAD) THESE PROBLEMS: High Blood Pressure? \_\_\_\_\_

Diabetes? \_\_\_\_\_ Blood clots (phlebitis) \_\_\_\_\_ Early stroke or heart attack \_\_\_\_\_

High Cholesterol \_\_\_\_\_ Osteoporosis \_\_\_\_\_ Colon Cancer \_\_\_\_\_

Uterine or cervix cancer \_\_\_\_\_ Ovary cancer \_\_\_\_\_ Breast Ca \_\_\_\_\_ Other Cancer \_\_\_\_\_

Do you SMOKE ? : No \_\_\_\_\_ Yes \_\_\_\_\_ \_\_\_\_\_ packs / day If No, did you quit? \_\_\_\_\_

Do you drink ALCOHOL ? : No \_\_\_\_\_ Yes \_\_\_\_\_ \_\_\_\_\_ drinks / day,, \_\_\_\_\_ drinks / week

Do you drink CAFFEINE containing drinks ? : No \_\_\_\_\_ Yes \_\_\_\_\_ \_\_\_\_\_ drinks / day

Have you ever used ILLEGAL DRUGS or abused NARCOTICS ? No \_\_\_\_\_ Yes \_\_\_\_\_

Have you ever been a victim of DOMESTIC VIOLENCE ? No \_\_\_\_\_ Yes \_\_\_\_\_ when? \_\_\_\_\_