Blue Skies Center for Women
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Name: ________________ Date of Birth: __________ Age: __________ Date: ________
Address: ________________________ S.S.#: __________ Occupation: __________
Phone (home): ______________ (work): ______________ (cellular/other): ______________
Chief Complaint: ____

Gynecological History

First day of last period: __________ Days between periods: __________ Bleeding days per month: ________
Age of first period: ________ Age at first intercourse: ________ Number of partners (lifetime): ________
Date of last pap test: ______________ Any abnormal pap tests?: ______________
Date of last mammogram: ______________ Any abnormal mammograms?: ______________
Have you had any sexual transmitted diseases?: ______________
Are you in a monogamous relationship?: Yes No If so, how long?: ______________

Obstetrical History

Number of pregnancies: ______________ Number of living children: ______________
Number of miscarriages: ______________ Number of terminations: ______________
Any pregnancy complications?: ______________

Surgical History

Surgery/ Hospitalization	When/ Complications	Surgery/ Hospitalization	When/ Complications

Medications	Allergies

Medical and Family History

	Patient	Family	Comments
Heart Disease/ Hypertension			
Stroke			
Respiratory disease/ Asthma			
TB (tuberculosis)			
Kidney disease			
Urinary tract problems			
Epilepsy/ Neurologic disorder			
Headaches			
Ear/ Nose/ Throat problems			
Bowel Disorder			
Jaundice/ Hepatitis			
Gallbladder disease			
Thyroid disease			
Anemia/ Blood disorder or clot			
Blood transfusion			
Breast disease			
Diabetes			
Cancer			
Psychiatric disorders			
Smoking: #/day			
How long?			
Alcohol: drinks/ wk			
Recreational Drug use			
Other:			

Date of last update: ______________________________