All information is kept confidential. If you are uncomfortable answering any questions, leave them blank; you can discuss them with Dr Dennis or his staff.

Current Medications: Please include ALL hormones, vitamins, herbs and over the counter medications.

Drug Name	**Dose**	**Drug Name**	**Dose**

General Medical History

0 Alcohol/drug addiction	0 Anemia	0 bleeding disorder
0 Arthritis	0 Asthma	0 bowel problems
0 Blood clots	0 Blood transfusions	0 cataracts
0 Broken bones	0 cancer _____	0 depression/anxiety
0 Chickenpox	0 eating disorder	0 gallbladder disease
0 Diabetes	0 headaches	0 heart disease/attacks
0 Glaucoma	0 hepatitis	0 high blood pressure
0 Heart murmur	0 HIV/AIDS	0 joint/back pain
0 High cholesterol	0 Kidney stones	0 lung disease
0 Kidney infection	0 pneumonia	0 sickle cell
0 Osteoporosis	0 seizures/epilepsy	0 tuberculosis
0 Endometriosis	0 thyroid disease	0 other_____
0 Stroke	0 arrhythmia	

Allergies

Drug/Food/Other	**Reaction**

Gynecological History

First day of your last menstrual period: _____ Age at your first period:_____

Usual number of days of bleeding with menses_____ Do you have cramping or excessive bleeding? _____ Describe:_____

_____

_____

Are you sexually active?_____Do you have pain with intercourse?_____
Any history of sexually transmitted diseases?_____
Have you ever used birth control or hormone replacement therapy? ____ Yes ____ No If yes, which and for how long?_____ When was your last PAP test? _____ Have you ever had an abnormal PAP? _____
Date of your last mammogram?_____

Obstetric History 0 NONE

Please include information about all pregnancies-births, miscarriages, abortions, ectopic (tubal).

Date	**Weight**	**Sex**	**Place Delivered**	**Type of Delivery**	**Complications**

Past Surgical/Injury History 0 NONE

Date	**Procedure**

Do you have a family history of any of the following? If so, please indicate family member's relation.

0 Ovarian Cancer_____ 0 Breast Cancer_____ 0 Uterine Cancer_____

0 Heart Disease_____ 0 Diabetes_____ 0 Stroke_____

0 Cystic fibrosis_____ 0 Birth Defects_____ 0 Osteoporosis_____

Social History

Have you ever smoked?_____ How long ago did you quit?_____ Still smoking?_____
How many do you smoke daily?_____ How soon after you wake up do you have your first cigarette?_____

Have you consumed an alcoholic beverage within the last year?_____ How often do you drink?_____ How many drinks do you normally have? _____ Have you had more than 6 alcoholic drinks at one time?_____

Do you or have you used an illegal street drug?_____ When was your last use?_____
What drug did you consume?_____