908 N Elm St, Suite 303
Hinsdale, IL 60521
630.920.1347 ph
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Legal Name: _____ **Today's Date:**_____

Preferred Name: _____ **Date of Birth:** _____

Primary Care Provider:_____ **Referred by:**_____

Age of First Menstrual Period:_____ **Date of Last Menstrual Period or Age at Menopause:**_____

Please list the date and results of your most recent tests (listed below)

TEST	DATE	RESULTS	ABNORMAL HISTORY (IF ANY)
Last Pap Smear			
Bone Density/Dexa			
Colonoscopy			
Mammogram			

Please list any allergies:
Date(s) of last Flu Vaccine:
Date(s) of Covid-19 Vaccine:

Please list any medications you currently use, including birth control or IUD:

	Drug Name	Dose	Frequency	Prescribing Doctor
Prescription Drugs				
↓				
↓				
↓				
Vitamins/Supplements/Herbs				
↓				

Surgical History: Have you ever had a reaction to anesthesia? _____

Surgery	Date	Surgery	Date
Hysterectomy		**Bladder Surgery (type)**	
Ovaries removed ☐Both ☐Right ☐Left		**Tubal Ligation ("Tubes tied")**	
LEEP/ Cervical Cone Biopsy		**Uterine Ablation**	
Please list any other surgery you have had and when it occurred:			

Check if you have had any of the following medical problems in the past:

Major Illness	Yes	Major Illness	Yes	Major Illness	Yes	Major Illness	Yes
NO KNOWN MEDICAL PROBLEMS		STD: If yes, what kind?		Urinary incontinence ☐Urge ☐Stress		Polycystic Ovarian Syndrome (PCOS)	
Anxiety		Osteoporosis		Thyroid disease		Blood Transfusion	
Depression		High Cholesterol		Cancer? If yes, what kind?		Other:	
Diabetes		High Blood Pressure		Sexual Dysfunction		Other:	
Asthma		Uterine Fibroids		Migraine/ Chronic Headache		Other:	

Social History: Check or fill in the most appropriate response.

Do you think of yourself as….	☐Straight/Heterosexual ☐Lesbian/Gay/Homosexual ☐Bisexual ☐Something Else ☐I don't know
What are your preferred pronouns?	☐She/Her ☐He/Him ☐They/Them ☐Ze/Zir
Do you smoke or use tobacco?	☐Yes ☐No ☐ Former smoker If yes or former: _____ # of packs/ cigarettes per day for _____# years?
Do you use an e-cigarette or vape?	☐Yes ☐No If yes, for how long? _____ weeks/ months/ years?
What is your occupation?	
Marital Status?	☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Domestic Partnership
How often do you exercise?	☐None ☐Less than 3 times per week ☐More than 3 times per week
Do you follow a specific diet?	
Do you drink alcohol?	☐Yes ☐No If yes: _____drinks per day/week/month.
Do you consume caffeine?	☐Never ☐Less Than 2 Cups Daily ☐2 or More Cups Daily ☐5 or More Cups Daily
Do you smoke or consume edible marijuana/THC?	☐Yes ☐No If yes, what type? _____ How often? _____
Do you use other recreational drugs?	☐Yes ☐No If yes, please list:: _____
Are you currently sexually active?	☐Yes ☐No
Have you ever been physically hurt or threatened by anyone in your life?	☐Yes ☐No ☐ Please, ask me about this without my family/partner present
Do you have pets at home?	☐Yes ☐No If yes, what kind?

Obstetric History:

Total # of Pregnancies:	Full Term Births:	Preterm Births:	Miscarriages:	Ectopic /Tubal Pregnancies:	Abortions:	Living Children:

Pregnancy history: Please fill in the answers for each pregnancy including miscarriages and abortions:

	Birth Date	GA Weeks	Length of Labor	Sex: M/F	Weight	Type of Delivery	Anesthesia	Place of Delivery	Preterm Labor Y/N	Comments/ Complications
1										
2										
3										
4										
5										

Family Medical History:

Does anyone in your family have a history of cancer: ☐Yes ☐No

Type of Cancer	Who has/had this cancer?	Age at Onset

Are you interested in Genetic Cancer screening: ☐Yes ☐No

Complete if any of your immediate relatives have had the following:

Major Illness	Relationship	Major Illness	Relationship	Major Illness	Relationship
Diabetes		Thyroid Disease		Osteoporosis	
High Blood Pressure		Kidney Disease		Alzheimer's Disease	
Stroke		High Cholesterol		Other Medical Info	