

ST. LUKE'S CENTER FOR ADVANCED GYNECOLOGIC CARE

1. NAME: _____ **DATE:** _____
(LAST) (FIRST) (MIDDLE)

2. REFERRED BY: _____ **AGE:** _____

3. APPOINTMENT REASON: _____

4. PAP SMEAR/ MAMMOGRAM

Date of most recent pap smear: _____ Result: _____

Date of most recent mammogram: _____ Result: _____

5. MEDICATIONS

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____

6. PREGNANCIES

Times Pregnant: _____ Living Children: _____ Stillborn: _____

Miscarriages: _____ Elective, Interruptions of Pregnancy: _____

Year	Infant Wt.	Sex/Name	Vag/CS	Complications: Mother	Complications: Infant

7. Smoking

Present: _____ Past: _____ Amount: _____ Date Stopped: _____

8. Alcohol

None: _____ Rarely: _____ Socially: _____ Regularly: _____

9. FAMILY HISTORY

	Age	Deceased	Health Problems
Father			
Mother			
Brothers			
Sisters			
Husband			
Children			
Grandparents			

Do any of the above family members have (please check all that apply)

- | | | | | | |
|-----------------|--------------------------|---------------|--------------------------|---------------------|--------------------------|
| Breast Cancer | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> |
| Ovarian Cancer | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> |
| Cervical Cancer | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> |

Other Cancers (specify): _____

Other hereditary illness (specify): _____

10. MEDICAL CONDITIONS

1. _____ 2. _____
3. _____ 4. _____

11. ALLERGIES:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Describe Reactions: _____

12. SURGERY OR HOSPITALIZATIONS

Date	Operation	Hospital	Complications

Transfusions: Yes: _____ No: _____ Number: _____

13. MENSTRUAL CYCLE

Age at onset: _____ Regular: YES NO
Intervals between menses: _____ Duration of Flow: _____
First day of last menstrual cycle: _____ Pain or cramps: YES NO
Problems: _____

14. PRESENT CONTRACEPTIVES (Please check all current methods):

Birth Control Pill	<input type="checkbox"/>	Foam/ VCF	<input type="checkbox"/>	Tubal Ligation	<input type="checkbox"/>
Ortho Evra Patch	<input type="checkbox"/>	Condom	<input type="checkbox"/>	Essure	<input type="checkbox"/>
Nuva Ring	<input type="checkbox"/>	Rhythm	<input type="checkbox"/>	Vasectomy	<input type="checkbox"/>
IUD	<input type="checkbox"/>	Diaphragm	<input type="checkbox"/>	Infertility	<input type="checkbox"/>
None	<input type="checkbox"/>			Other	<input type="checkbox"/>
Pregnancy acceptable	<input type="checkbox"/>			Please Specify: _____	
Would like to discuss Birth Control Options	<input type="checkbox"/>			_____	

15. STDS (please check all current STDS)

Chlamydia	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>
HIV	<input type="checkbox"/>	Condyloma	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>
HPV	<input type="checkbox"/>				

16. PERSONAL HISTORY

Height: _____ Weight: _____ Highest non-pregnant weight: _____