Patient Name _____ DOB_____

FAMILY HISTORY

Illness	Relative	Age onset	Illness	Relative	Age onset
Y N Breast Cancer			Y N Ovarian Cancer		
Y N Colon Cancer			Y N Other Cancer		
Y N Heart Disease			Y N Hypertension		
Y N Depression/Anxiety			Y N Stroke		
Y N Thyroid Disease			Y N Osteoporosis		
Y N Bleeding Disorders			Y N Mental Retardation		
Y N Birth Defects			Y N Genetic Disease		
Y N Diabetes			Y N Other		

SOCIAL HISTORY

Tobacco Use Y N How Much_____ Number of Years_____
Alcohol Use Y N How Much_____
Recreational Drug Use Y N How Much_____ Number of Years_____
Calcium Intake Y N Calcium Supplement Y N _____
Caffeine Intake Y N How Much_____
Exercise Y N How often_____ Type_____

MEDICATIONS (INCLUDING OVER THE COUNTER)

Medication	Medication	Medication

See Attached List _____

MENSTRUAL HISTORY

Age at first menstrual period _____
Cycle length_____ Flow length_____
Menstrual flow – Light_____ Moderate_____ Heavy _____

If you have stopped having menstrual periods, at what age did you have your last one _____

Date Updated and Reviewed

_____ _____ _____ _____ _____ _____ _____

BROOME OBSTETRICS AND GYNECOLOGY, P.C.

Patient Name _____ Date _____
Date of Birth _____ Primary Care Physician _____
Referred By _____ Physician Address _____
Specialists _____

ALLERGIES (REACTIONS) _____ (_____) _____ (_____)
_____ (_____) _____ (_____) _____ (_____)

PERSONAL MEDICAL HISTORY:

Y N	Heart Disease	Y N	Hypertension	Y N	High Cholesterol
Y N	Stroke	Y N	Bleeding Disorders	Y N	Mitral Valve Prolapse
Y N	Asthma	Y N	Thyroid Disease	Y N	HIV
Y N	Osteopenia	Y N	Osteoporosis	Y N	Joint Replacement
Y N	Diabetes	Y N	Anxiety	Y N	Depression
Y N	GERD	Y N	Peptic Ulcer Disease	Y N	Migraines
Y N	Cancer	Y N	Seizures	Y N	STD Exposure

Other _____

GENETIC TESTING:

Y N BRCA Who was tested _____ Discussed _____
Results _____

Y N Multi-Gene Who was tested _____ Discussed _____
Results _____

FAMILY PLANNING: _____

OPERATIONS/HOSPITALIZATIONS:

Date	Procedure	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OBSTETRICAL HISTORY:

Date	Type of Delivery (Complications)	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DEXA scan Y N Date/Where _____ _____ _____
Colonoscopy Y N Date/Where _____ _____ _____
Gardasil Vaccine Y N Date/Where _____ _____ _____

Date Updated and Reviewed

_____ _____ _____ _____ _____ _____ _____