

When was your last pap smear? \_\_\_\_\_

Have you ever had an ABNORMAL PAP SMEAR? NO YES If yes, when and how was it treated?

Check any of the infections you have had: What YEAR?

- gonorrhea
- genital herpes
- genital warts (condyloma)
- chlamydia
- syphilis
- HIV/AIDS
- PID (pelvic inflammatory disease)/tubal infection

Have you been tested for the HIV (AIDS) virus? NO YES When? \_\_\_\_\_ What was the result? \_\_\_\_\_

Do you know how to examine your breasts? NO YES Do you examine your breasts each month? NO YES

When was your last MAMMOGRAM? \_\_\_\_\_ What was the result? \_\_\_\_\_

With whom do you have sex? women men both neither

Check any of the following methods of BIRTH CONTROL you have used:

<u>Method</u>	<u>Dates of usage</u>	<u>Problems</u>
<input type="checkbox"/> condom		
<input type="checkbox"/> foam		
<input type="checkbox"/> diaphragm		
<input type="checkbox"/> Norplant		
<input type="checkbox"/> Depo-Provera		
<input type="checkbox"/> oral contraceptives or "the pill"		
<input type="checkbox"/> intrauterine device (IUD)		
<input type="checkbox"/> rhythm		

OBSTETRICAL HISTORY

How many times have you been pregnant? \_\_\_\_\_

Check if you have had any of the following? How MANY and what YEAR?

- vaginal deliveries
- cesarean sections
- ectopic or tubal pregnancies
- premature labor/deliveries
- miscarriages
- abortions
- babies with birth defects

DELIVERIES

	Date	#weeks	Weight	Sex	Hours in labor	Vaginal/cesarean	Complications—mom/child	Doctor
①								
②								
③								
④								

FAMILY HISTORY

	<u>Age</u>	<u>Health problems</u>	<u>If deceased, age and cause</u>
Mother			
Father			
Sister(s)			
Brother(s)			

YOUR SIGNATURE, PLEASE