Patient Medical Information
(please be as complete and accurate as possible)

1. List any medical problems or surgeries you or your partner may have had:

You _____ **Your Partner**_____

_____ _____

2. List all medications you or your partner are currently taking or any allergies to medications you may have:

You _____ **Your Partner**_____

_____ _____

3. Have you or your partner had any sexually transmitted diseases?

You_____ **Your Partner**_____

_____ _____

4. Do you or your partner drink, smoke or use illicit drugs? If yes, please list

You_____ **Your Partner**_____

5. When was your last menstrual period? How often do you have a period? Height? Weight?

_____ _____ _____ _____

6. List all your previous pregnancies and their outcomes by year:

Month/Year	Pregnancy Outcome	Month/Year	Pregnancy Outcome
_____	_____		
_____	_____		
_____	_____		
_____	_____		

7. List all your previous treatments and their outcomes by year:

Month/Year	Treatment/Outcome	Month/Year	Treatment/Outcome
_____	_____		
_____	_____		
_____	_____		
_____	_____		

8. When was the last time you had a full physical exam? _____Pap smear?_____

_____

Patient Signature

Date