General Information		
Name:	Today's Date:	
Date of Birth:	Age:	
Referring physician:	Family physician:	Other physician:

OB/GYN history		
Number of pregnancies:	Number of children:	Number of miscarriages:
Number of vaginal deliveries:	Number of cesarean deliveries:	Number of adopted children:
Age period started:	Number days period lasts:	Days between periods:
Age of menopause:	Date of last pap smear:	
Have you ever been treated for an abnormal pap? NO YES	If yes, please explain:	
circle all that apply: IRREGULAR BLEEDING VAGINAL DISCHARGE HYSTERECTOMY IUD HPV VACCINE ENDOMETRIAL ABLATION DEPO-PROVERA HORMONE REPLACEMENT		
Date of last mammogram:	Results:	
Date of last colonoscopy:	Results:	

Surgical history
Have you ever had problems with general anesthesia? NO YES

Medical history/Medical problems such as: thyroid disorders, blood clots, sleep apnea, heart diseases, hypertension, ?, and ?

Social history	YES	NO	Frequency
Alcohol			
Smoking			
Other			

Family cancer history: type of cancer	Family relation