Centra Medical Group Women's Center
2007 Graves Mill Road
Forest, VA 24551
(434)385-8948

Name: _____ Date of Birth: _____ Today's Date: _____

Do you identify as: ☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other: _____
Gender identity: ☐ Female ☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF
☐ Non-Binary ☐ Other: _____ ☐ Decline to answer

Medical History (any new from last visit): ☐ None

☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Polycystic Ovaries (PCOS)
☐ High blood pressure
☐ Heart disease
☐ High Cholesterol
☐ Asthma
☐ Alcohol/Drug abuse
☐ Anxiety or Depression
☐ Thyroid disease: Hypothyroid
☐ Thyroid disease: Hyperthyroid
☐ Ovarian cysts
☐ Endometriosis
☐ Uterine Fibroids
☐ Osteoporosis
☐ Other: _____
☐ Autoimmune disease
☐ Ovarian cancer
☐ Uterine cancer
☐ Breast cancer
☐ Colon cancer
☐ Melanoma
☐ Pancreatic cancer

Social History: Single Married Divorced Widowed

Occupation: _____ Student: ☐ Yes ☐ No School: _____
Do you use tobacco? ☐ Yes ☐ No ☐ Previously How many packs/cigarettes per day? _____
Do you use alcohol? ☐ Yes ☐ No ☐ Previously How many drinks per day/week? _____
Do you use drugs? ☐ Yes ☐ No ☐ Previous1y What kind? _____ How often? _____
Diet restrictions/Special diet: _____

OB/GYN History

Are you currently pregnant? ☐ Yes ☐ No First day of your last period: _____
Age of first period: _____ How many days between periods? _____ How long do your periods last? _____
Cramping during periods? ☐ Yes ☐ No Flow: ☐ Heavy ☐ Medium ☐ Light Clots: ☐ Yes ☐ No
Pain level during periods mild or severe _____ out of 10

Please describe your sexual activity in the past year (check all that apply):

☐ I was in a monogamous relationship with a man (I had sex with only one man)
☐ I was in a monogamous relationship with a woman (I had sex with only one woman)
☐ I had more than one male partner
☐ I had more than one female partner
☐ I had both male and female partners
☐ I did not have any sexual partners
☐ Other: _____

Do you have a history of sexually transmitted disease? Yes No Please specify type: _____

Have you had 3 doses of the HPV vaccine? Yes No
What do you currently use to prevent pregnancy (contraception)? _____
What have you used previously? IUD Pills Condoms Patch Nuvaring Other: _____
Are you interested in changing your method of contraception? Yes No

Date of last pap smear: _____ Date of last mammogram: _____ Date of last colonoscopy: _____

How many times have you been pregnant? _____ Number of children? _____

Birth/Miscarriage History

Date of birth/miscarriage	Weeks	Vag/CSection	Pain Relief Used	F/M	Weight	Name	Place of Birth	Complications

Surgical History (any new from last visit) ☐None

Date	Surgery	Date	Surgery

Medication (please include vitamins, over the counter medications) ☐None

Medication	Dose	How often do you take it?

Medication and Food Allergies ☐ None

Allergy _____ Reaction (hives, swelling, etc...) _____

Allergy _____ Reaction (hives, swelling, etc...) _____

Allergy _____ Reaction (hives, swelling, etc...) _____

Allergy _____ Reaction (hives, swelling, etc...) _____

Family Medical History (any new from last visit- please include relationship to you- i.e. parents, siblings. grandparents)

Diagnosis	Family Member	Diagnosis	Family Member	Diagnosis	Family Member
Diabetes		Melanoma		Osteoporosis	
Stroke		Pancreatic cancer		Autoimmune disease	
High blood pressure		Colon cancer		Hypothyroid	
Heart disease		Ovarian cancer		Hyperthyroid	
Depression/Mental Illness		Uterine cancer		Alcohol/Drug Abuse	
Kidney disease		Breast cancer		Other	

Concerns or problems you'd like to discuss today: _____

_____

_____