



Alicia Costantino, M.D.

Carol Dehasse, M.D.

Patient Name: _____ DOB: _____ Age: _____ Race: _____

Occupation: _____ Referring Physician: _____

Reason for visit: _____ Date: _____

MEDICATION ALLERGY/SENSITIVITY

List all medication allergies and types of reactions: **None**

CURRENT MEDICATIONS BEING TAKEN & DOSAGES

MEDICAL HISTORY (Check appropriate boxes)

- | | You | Family |
|---|--------------------------|--------------------------|
| 1. High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Asthma/Lung Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Thyroid Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Headaches/Migraines | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Nervous Disorder or Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Stomach, Bowel, or Gallbladder Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Kidney or Bladder Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. AIDS (HIV) | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Hepatitis (Type: _____) | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Anemia or Blood Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Blood Transfusion | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Breast Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Fertility | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Female or Sexual Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Chlamydia, Gonorrhea or Herpes | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Syphilis | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Birth Defects or Inherited Diseases | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Sexual Abuse or Domestic Violence | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Other Medical Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. No Known Medical Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Immunizations up-to-date | <input type="checkbox"/> | <input type="checkbox"/> |

HOSPITALIZATIONS. List operations/serious illnesses that have required hospitalization. If more than four check this box

Month/Year	Illness or Operation	Complications	
		Yes	No
/		<input type="checkbox"/>	<input type="checkbox"/>
/		<input type="checkbox"/>	<input type="checkbox"/>
/		<input type="checkbox"/>	<input type="checkbox"/>
/		<input type="checkbox"/>	<input type="checkbox"/>

MENSTRUAL HISTORY

LMP: ____/____/____

Menarche _____

Interval _____

Length of Period _____

Abnormalities:

Excessive Bleeding _____

Discharge _____

Pain _____

None _____

CONTRACEPTIVE HISTORY

Oral Contraceptives Current Past

Type(s): _____

IUD

Diaphragm

Norplant

Sponge

Spermicide

Depo-Provera

Condoms

Sterilization

Other _____

SEXUAL HISTORY

Sexually Active **Y / N**

Age First Intercourse _____

# of Births	DOB MM/YY	Sex	Type of Delivery	Weight At birth	Complications	
					Yes(list)	No
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

28. Last Pap Smear _____

29. History of abnormal Pap Smears?

If yes, when and where treated: _____

30. Last mammogram?(Date/Place) _____

31. History of abnormal mammogram readings?

SUBSTANCE ABUSE (Circle only those used)

32. Alcohol: Type: _____ Amt: _____

33. Tobacco: Type: _____ Amt: _____

34. Street Drugs: Type: _____ Amt: _____

Number of Pregnancies: _____

Number of Miscarriages: _____

Number of Abortions: _____



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CONFIDENTIAL GYNECOLOGY HISTORY

1. Please indicate your present method of birth control.	YES	NO
<input type="checkbox"/> None, or _____		
2. Do you think you might be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
3. Your last menstrual period began on _____ / _____ / _____		
4. Write in any changes related to your period: _____ _____		
5. Have you noticed any unusual vaginal odor, discharge, or itching?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you sexually active? If yes, how many partners have you had in the past year? _____ If yes, do you have pain during intercourse? <u>Y / N</u>	<input type="checkbox"/>	<input type="checkbox"/>
7. How would you describe your sexuality? (circle one) Heterosexual Lesbian Bisexual Not Sexually Active		
8. Are you worried you might have a sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever been diagnosed with gonorrhea, Chlamydia, herpes, syphilis, or HIV(AIDS)? If yes, when and where were you treated _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you found any abnormalities while examining your breasts?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had an abnormal finding on a mammogram? Date and place of last mammogram _____	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you had a pelvic ultrasound done within the last 12 months? If yes, date and place of ultrasound _____	<input type="checkbox"/>	<input type="checkbox"/>
13. Since your last visit have you had any recent operations, serious illnesses, or injuries? If yes, describe _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
14. Are there any other problems you would like to discuss with me? If yes, describe _____ _____	<input type="checkbox"/>	<input type="checkbox"/>