Lifestyle (although these subjects can be embarrassing, it is important that you give an honest answer to every question.)

Yes No Your answers are kept confidential.

Staff use only:

1. What is your occupation? _____
2. ☐ ☐ Do you **ALWAYS** use a bike helmet, auto safety belt, and sunscreen? (Circle the ones you use.)
3. ☐ ☐ Do you consider your diet healthy?
4. ☐ ☐ Do you exercise? What type? _____ How often? _____
5. ☐ ☐ Are you up-to-date on your vaccinations? Date of most recent: _____
   ☐ DPT (diptheria, pertussis, tetanus) ☐Rubella ☐Hepatitis ☐Polio ☐ other_____
6. ☐ ☐ Do you do monthly self breast exams? ☐ always ☐ sometimes ☐ never
7. ☐ ☐ Have you ever had a **Mammogram?** Date of most recent: _____
8. ☐ ☐ Are you currently sexually active? At what age did you begin having intercourse? _____
   Number of sex partners in the last 6 months? _____ ☐ male ☐ female ☐ both
9. ☐ ☐ Do you use condoms? ☐ always ☐ sometimes ☐ never
10. ☐ ☐ Have you had a new sexual partner(s) in the last 6 months?
11. ☐ ☐ Does you partner(s) have other sexual partner(s)?
12. ☐ ☐ Do you feel you've ever been abused or used sexually?
13. ☐ ☐ Do you ever feel afraid of or threatened by your partner(s) or other people in your life?
14. ☐ ☐ Do you have any questions about sex? _____
15. ☐ ☐ Do you have problems with urinary incontinence (holding or leaking of urine)?
16. ☐ ☐ Do you use cigarettes, tobacco, street or recreational drugs, and/or alcohol?
    If yes, how often and amount: _____
17. ☐ ☐ Are you exposed to dangerous chemicals or situations in your work?
    If yes, explain: _____
18. ☐ ☐ Do you use any alternative medicine or holistic therapies? Type:_____

Menstrual Periods

19. ☐ ☐ Do your menstrual periods occur regularly? Date your last period began: _____
    Age at first menstrual period: _____ yrs old. Age at menopause: _____ yrs old
    Periods come every _____ days and last for _____ days
    Blood flow during period is: ☐ light ☐ moderate ☐ heavy ☐ excessive
20. ☐ ☐ Are your periods painful, needing medication or interferring with your usual activities?
21. ☐ ☐ Do you have bleeding or pain between periods?

Birth Control Methods

22. ☐ ☐ Do you use a form of birth control? Circle method(s) currently used

pills brand: _____	rhythm, calendar, Natural Family Planning
birth control injection / Depoprovera	skin implant (rods) / Norplant
diaphragm/cervical cap	IUD / intrauterine device
foam, suppositories, creams , jelly	tubal ligation (sterilization)/ tubes tied or removed
condoms	partner had vasectomy
withdrawal or pulling out	none

23. ☐ ☐ Have you had problems with any current or previously used methods?
    Method and type of problem _____
24. ☐ ☐ Do you want to change your method of birth control? To what type? _____

Questions or Concerns to discuss with Doctor today

25. ☐ ☐ Do you have any questions or concerns that you wish to discuss with your doctor today?
    If yes, please list: _____

reviewed by:
M.D.

Patient Signature: _____ **Date** _____