

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Family Doctor \_\_\_\_\_

Age \_\_\_\_\_

Number of pregnancies \_\_\_\_\_

Last Pap \_\_\_\_\_

Number of miscarriages \_\_\_\_\_

Last period \_\_\_\_\_

Number of births \_\_\_\_\_

Type of contraception \_\_\_\_\_

Why are you seeing the doctor today? \_\_\_\_\_

\_\_\_\_\_

Have you ever seen a gynecologist before? Yes  No  If yes, what for?

\_\_\_\_\_

Have you ever seen Dr. Gail Lam before? If so, what year? \_\_\_\_\_

Medical History	Yes	No
Migraines		
Epilepsy		
Multiple Sclerosis		
Asthma		
High Blood pressure		
Breast Cancer		
Kidney Problems		
Liver problems		
Blood clots in leg or lungs		
Diabetes		
Thyroid		
Lupus		
Cancer		
Other:		

Surgical History		
Year	City	Type of operation

Family History of Medical Diseases: (Cancer, high blood pressure, diabetes, thyroid, etc)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medication – Including dosage \_\_\_\_\_

\_\_\_\_\_

Herbal Supplements \_\_\_\_\_

\_\_\_\_\_

Allergies to medication \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Smoker: Yes  No

If yes how many packs per day? \_\_\_\_\_

Street drugs: Yes  No

If yes please specify \_\_\_\_\_

\_\_\_\_\_

Alcohol: Yes  No

Drinks per week \_\_\_\_\_