



Joanne Vogel, M.D. Inc.
 2301 Camino Ramon, Suite 200
 San Ramon, California 94583
 Phone: (925) 358-0305 Fax: (925) 358-0309

WOMEN'S HEALTH HISTORY

Patient Name _____ Patient Date of Birth _____ Date Form Completed _____

Medications: _____

Allergies: _____

GYNECOLOGICAL HEALTH HISTORY

First day of last period: _____

Are your periods regular? Yes No

Are they heavy? Yes No

Are they painful? Yes No

Have you ever had sex? Yes No

How many times have you been pregnant? _____

How many children do you have? _____

Have you had any miscarriages? Yes No

Date of last PAP smear: _____ Results: _____

Date of last mammogram: _____ Results: _____

Sexual partners are: Men Women Both

Abortions? Yes No

PAST MEDICAL HISTORY

What significant illnesses have you had? _____

What surgeries have you had (with dates)? _____

HABITS

Do you currently or have you in the past used:

Tobacco

Previously Yes No

Currently Yes No

Frequency: _____

Alcohol

Yes No

Yes No

Frequency: _____

Street Drugs (including marijuana)

Yes No

Yes No

Frequency: _____

FAMILY HISTORY

Have any relatives had the following?

Cancer

Yes No

Who? _____

High Blood Pressure / Heart Disease

Yes No

Who? _____

Osteoporosis

Yes No

Who? _____

Other

Who? _____

What concerns do you have today (reason for visit)? _____

 Patient Signature

 Print Name

 Date