Family History: Please check the diseases below that affect your family members, and list their relation to you:

Breast Cancer_____	Ovarian Cancer _____	Colon Cancer _____
Uterine Cancer _____	Uterine Fibroids _____	Other Cancer _____
Diabetes _____	Heart Disease _____	Osteoporosis _____
High Cholesterol _____	Thyroid Disease _____	Hypertension _____
Birth Defects _____	Mental Retardation _____	Endometriosis _____
Blood Clots/DVT _____	Genetic Disorders _____	Other _____

Please check the method(s) of birth control that you are currently using:

__Birth Control Pill/Patch ___Condoms ___NuvaRing ___Diaphragm ___Vasectomy ___ IUD

___Tubal Ligation ___Spermicide ___ Withdrawl ___Rhythm/NFP ___Abstinence ___ None

Are you still having periods? **Yes/No** If yes, are they: Regular/ Irregular

If no, when did they stop? _____

Have you had a hysterectomy? **Yes/No** If yes, reason? _____

Number of days of flow _____ Light/ Moderate/ Heavy

How old were you when your periods began? _____ Do you still have your ovaries? Yes/ No

How many days from the start of one cycle to the start of another? _____

Last Period: ___/____/____ Last Mammogram: ___/____/____ Last Pap: ___/____/____

Pregnancy History: Number of pregnancies? _____ Miscarriages? _____ Abortions?_____

Number of living children? _____ What years were your children born? _____

How many sexual partners have you had in the past year? _____

Are you satisfied with your sex life? **Yes/No** If no, why? _____

Do you experience dryness or pain with sexual activity? Yes/No

Do you use lubricants? **Yes/ No** Any loss in sexual interest? Yes/No

Do you orgasm as easily and frequently as you desire? Yes/No

Are you trying to get pregnant? **Yes/No** If so, for how long? _____

History: Have you ever been emotionally, sexually, or physically abused? Yes/ No

If so, please explain _____

Do you smoke? **Yes/ No** How many packs per day? _____ For how many years? _____

Do you drink alcohol? **Yes/No** How many drinks per week? _____ For how many years? _____

Do you use recreational drugs? **Yes/No** If yes, which drugs? _____

Have you ever been addicted to drugs or alcohol? **Yes/No**

Do you drink caffeinated beverages? **Yes/ No** How many per day? _____

What kind of exercise do you do? _____ How often? _____

Please check any of the following symptoms that apply to you:

__Hot Flashes	__Fatigue	__Anxiety
__Irritability	__Suicidal Thoughts	__Not Sleeping
__Recent Wt Gain	__Visual Discturbances	__Waking Early
__Night Sweats	__Pain with Urination	__Other_____
__Mood Swings	__Migraines	
__Recent Wt Loss	__Depression	

__Loss of Urine with Cough or Sneeze __Frequent Urination

Please Print Name: _____

Signature: _____ Date: _____

Physican Signature: _____ Date: _____

David D. Hodge M.D., P.C

Name_____ Today's Date_____

Address_____ Age_____ Birth Date_____

_____ Occupation_____

Telephone (H) _____ (C) _____

What is the reason for your visit?_____

Do you have any drug allergies? **YES/ NO** Latex Allergy? YES/ NO

Allergy	Reaction
_____	_____
_____	_____

What is your weight _____ height _____

Please check the conditions that you have now or have had:

__Breast Cancer	__Heart Disease	__Vaginal Infections
__Cervical/Ovarian/ Uterine Cancer	__Heart Murmur	__Pelvic Inflammatory Disease
__Abnormal Mammogram	__Mitral Valve Prolapse	__Venereal Warts/HPV
__Fibrocystic Breast	__Hypertension	__HIV/AIDS
__Ovarian Cysts	__High Cholesterol	__Hepatitis
__Uterine Fibroids	__Kidney Stones/Disease	__Herpes
__Bleeding Problems	__Liver/Gallbladder Disease	__Gonorrhea/Chlamydia
__ Blood Clots/ DVT	__Osteoporosis	__Syphilis
__ Endometriosis	__Thyroid Disease	__Trichomonas
__Arthritis	__Ulcer Disease	__Major Accident
__Asthma / Bronchitis	__Chicken Pox	__Depression/Anxiety
__Epilepsy/Seizures	__Rubella/German Measles	__Other Psychological Illness
__Diabetes	__Abnormal Pap Smears	__Other Illness_____

Have you ever had surgery?

Surgery	Hospital	Date	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list current medications:

Medication	Dosage	For How Long
_____	_____	_____
_____	_____	_____
_____	_____	_____

What vitamins or herbal supplements do you use? _____

Immunization History: ___ Up to Date ___ Unsure __Need Immunizations

What is your nationality? _____

Marital Status _____ Years in current relationship_____

Partner's Name_____ Partner's Occupation _____

Partner's History: Hepatisis ____ Herpes ____ Any sexually transmitted diseases _____