**101 Holbrook Street**
**Danville, VA 24541**
**(434) 792-7765 - Phone**
**(434) 793-4061 - Fax**

**GYNECOLOGICAL HISTORY:**

First day of last menstrual period:________________________________

**Circle if YOU have had now or in the past:**

Sexually Transmitted Disease / Endometriosis / Ovarian Cysts / Abnormal Pap Smears / Fibroids

If not menopausal, what method of birth control do you use?________________________________

**SOCIAL HISTORY**: (Circle all that apply)

Married / Single / Divorced / Widowed

Smoke Cigarettes: Yes / No    Packs per Day:________________

Alcohol: Yes / No    Drinks Per Week:______________

Recreational Drug Use: ________________________________________________

Sexual Orientation: Heterosexual / Homosexual

Physical Abuse / Sexual Abuse / emotional abuse

**FAMILY MEDICAL HISTORY (example: heart disease, cancer, diabetes, high blood pressure, etc.)**

Mother:

Father:

Brothers:

Sisters:

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Children:

**PREVENTATIVE HEALTH (Please include date and result of last test, indicate not done if never done):**

Colonoscopy: ________________________________________________

Mammogram: ________________________________________________

Pap Smear: ________________________________________________

Bone Density: ________________________________________________

Cholesterol Screening: ________________________________________________

Thyroid Screening: ________________________________________________