

Name: _____

	Yes	No
Have you ever had a mammogram?		
Have you ever had a colonoscopy?		

This column for doctor's use only

Sexual History

	Yes	No
Are you sexually active?		
Do you use/require contraception?		
Current Birth Control Method _____		
Have you ever used?		
Birth Control Pills		
IUD		
Other: _____		

Number of sexual partners in last 5 years:
(circle one) 0 1 1-5 >5

Any new partners?		
Do you use condoms?		

Obstetrical History (include miscarriages or abortions)

Year	Procedure (D&C, cesarean, vaginal delivery)

Urologic History

	Yes	No
Do you lose urine with cough/sneeze?		
Other bladder problems: _____		

Surgical History

	Yes	No
Have you ever had pelvic or abdominal surgery?		
Procedure: _____		
Other surgery? (i.e. breast biopsy)		

Signature _____

Date _____