**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**_____

_____

_____

**Smoker:** **Yes** ☐ **No** ☐

**If yes how many packs per day?** _____

**Street drugs:** **Yes** ☐ **No** ☐

**If yes please specify** _____

_____

_____

**Alcohol:** **Yes** ☐ **No** ☐

**Drinks per week** _____

**Allergies to medication**_____

_____

_____

_____

_____

_____

_____