SHIRAZ H KASSAM, M.D.

PATIENT'S NAME_____ **DATE OF BIRTH**_____

Dear Patient: The purpose of this form is to help you to remember everything that should be checked. Please fill it out completely.

CHECK THE MAIN REASON YOU CAME TO SEE THE DOCTOR

Pregnancy ( ) Irregular Bleeding ( ) Breast Check ( ) Hot Flashes ( )
Pain ( ) Family Planning ( ) Sexual Problem ( ) Pap Test ( )
Discharge ( ) Infertility ( ) Any other ( ) _____

MENSTRUAL HISTORY

Menstruation started at age_____. Number of days periods last_____.
Number of days from start of one to start of next period_____.
Date of last normal menstrual period (1st day of last period) _____.

OBSTETRIC HISTORY

How many times have you been pregnant?_____. How many full-term babies?_____. Premature?_____
Miscarriages?_____ Ectopics?_____Stillborns?_____ Abortions?_____

Month and year of your last Pap test_____ Was it normal_____

CHECK YES OR NO FOR EACH OF THE FOLLOWING QUESTIONS

	Yes	NO
Do you perform Breast Self Examination (BSE)	( )	( )
Are sexual relations uncomfortable?	( )	( )
Are you troubled with a discharge	( )	( )
Do you have urinary problems?	( )	( )
Do you feel like something is pushing out of your vagina?	( )	( )
Do you lose urine when you cough or laugh?	( )	( )
Do you take birth control?	( )	( )
Do you drink?	( )	( )
Do you smoke?	( )	( )
Are you on any medications at present?		
Please list _____		
Have you even been hospitalized?	( )	( )
Have you ever had any serious injuries?	( )	( )
Have you even been operated on?	( )	( )
List operations and dates_____		
Are you allergic to any medications?	( )	( )
Please list _____		
HAVE YOU, SINCE 1978		
Used drugs intravenously for non medical purposes?	( )	( )
Been the sex partner of men: who use IV drugs, are bisexual, or have HIV Infection?	( )	( )
Immigrated from a country where heterosexual transmission of HIV infection plays a major role(Haiti, Certain Central African countries)?	( )	( )
Received blood or blood products prior to March 1985	( )	( )
Engaged in Prostitution?	( )	( )
Been artificially inseminated?	( )	( )
Been a victim of rape?	( )	( )

CHECK ANY OF THESE YOU HAVE HAD

Anemia ( ) Diabetes ( ) Kidney Trouble ( ) Blood clots ( ) Heart Trouble ( ) VD ( )
Warts ( ) Convulsions ( ) High Blood Pressure ( ) Herpes ( ) Exposure to HIV ( )

CHECK ANY OF THE FOLLOWING OCURRING IN YOUR FAMILY

Cancer ( ) Birth defects ( ) High Blood Pressure ( ) Diabetes ( ) Strokes ( )
Mental Illness ( ) Twins ( ) Other ( )