

Date ___/___/___ Name _____ Date of Birth ___/___/___ Height? _____

Reason for my visit today is _____

First day of last period? ___/___/___ Last pap smear? ___/___/___ Last mammogram? ___/___/___

Last Bone Density? ___/___/___ Last cholesterol check? ___/___/___ Last colonoscopy? ___/___/___

What do you use for birth control? _____ Who is your primary care physician? _____

Are you allergic to any medications? _____

What type of reaction did you have? _____

How many times have you been pregnant? _____ Are you taking any medications? Y / N Please list below.

Name of medicine	Strength?	How often?	Prescribed for?	Prescribed by?

Age when periods started? _____ How many days between periods? _____ How many days does period last? _____

Age of first intercourse? _____ Number of different sexual partners? _____

Have you ever had an abnormal pap smear? Y / N When? _____ What was the diagnosis? _____

What was the treatment? _____ Have you ever had a sexually transmitted disease? Y / N

Which type? Chlamydia Gonorrhea HIV HPV Herpes PID Syphilis Trichomaniasis

PREGNANCY HISTORY (please list ALL pregnancies)

Month/Year	Sex	Pounds and Ounces	Full Term or Number of Weeks	How long was your labor?	What type of delivery did you have?	Location?
1)						
2)						
3)						
4)						
5)						
6)						
7)						
8)						

YOUR PAST MEDICAL HISTORY:

Benign Breast Conditions? Y / N	High Blood Pressure? Y / N	Cancer ? Y / N Type? _____
Breast Implants? Y / N	Diabetes? Y / N	Bowel Disorders? Y / N
Asthma? Y / N	Epilepsy or Seizures? Y / N	Kidney Disorders? Y / N
Heart Disease? Y / N	Hepatitis? Y / N	Thyroid Disease? Y / N
Hyperlipidemia? Y / N	Osteoporosis? Y / N	Fibroids? Y / N
	Ovarian Cysts? Y / N	Endometriosis? Y / N

Please list Type and Date of any surgeries below:

Any other past medical history for you?

What is your occupation? _____ Are you : Single Married Separated Divorced Widowed

What is your ethnic background? _____

What is your sexual preference? Abstinent Bisexual Heterosexual Homosexual

Are you currently sexually active? Y / N

Do you smoke? Y / N Packs per day _____ How many years have you smoked? _____

Are you a past smoker? Y / N Stopped smoking ____/____/____

Any substance abuse? Y / N Type? _____

Any history of domestic violence? Y / N

Do you drink any alcohol? Y / N How often? Binge Daily Occasional Rare Social Weekend

Do you drink any caffeine? Y / N

Do you do any regular exercising? Y / N Type? _____ How many times per week? _____

FAMILY HISTORY :

Were you adopted? Y / N

Has anyone in your family had Breast Cancer? Y / N Which family member? _____ Maternal or Paternal?

Has anyone in your family had Colon Cancer? Y / N Which family member? _____ Maternal or Paternal?

Anyone have Ovarian Cancer? Y / N Which family member? _____ Maternal or Paternal?

Anyone have Uterine Cancer? Y / N Which family member? _____ Maternal or Paternal?

Anyone have High Blood Pressure? Y / N Which family member? _____ Maternal or Paternal?

Anyone ever have a Stroke? Y / N Which family member? _____ Maternal or Paternal?

Anyone have Diabetes? Y / N Which family member? _____ Maternal or Paternal?

Anyone have Thyroid Disease? Y / N Which family member? _____ Maternal or Paternal?

Anyone have Heart Disease? Y / N Which family member? _____ Maternal or Paternal?

Anyone have Colon Polyps? Y / N Which family member? _____ Maternal or Paternal?

Anyone have Osteoporosis? Y / N Which family member? _____ Maternal or Paternal?

Which Pharmacy do you use? _____ Street and City: _____

We must have a pharmacy listed in your chart.