Name_____ Date of Birth _____ Date _____

Personal Medical History

Do you have a history of any of the following:					
		Describe			Describe
Measles, chicken pox	☐ Yes ☐ No		Blood Clot/Legs	☐ Yes ☐ No	
Anemia	☐ Yes ☐ No		Blood Clot/Lungs	☐ Yes ☐ No	
Bladder/Kidney Disease	☐ Yes ☐ No		Breast Lump	☐ Yes ☐ No	
Bone/Joint Disease	☐ Yes ☐ No		Diabetes	☐ Yes ☐ No	
Bowel Disease	☐ Yes ☐ No		Heart Disease-Type?	☐ Yes ☐ No	
Lung Disease/Asthma	☐ Yes ☐ No		High Blood Pressure	☐ Yes ☐ No	
Neurologic Disease	☐ Yes ☐ No		Migraine Headaches	☐ Yes ☐ No	
Rheumatic Fever	☐ Yes ☐ No		Varicose Veins	☐ Yes ☐ No	
Stomach Problems/Ulcer	☐ Yes ☐ No		Stroke	☐ Yes ☐ No	
Tuberculosis	☐ Yes ☐ No		Cancer	☐ Yes ☐ No	
Pneumonia	☐ Yes ☐ No		When?		Type?
Liver Disease/Hepatitis	☐ Yes ☐ No		Depression/Anxiety	☐ Yes ☐ No	
Thyroid Disease	☐ Yes ☐ No		other		

Surgery

Have you ever had an operation? ☐ Yes ☐ No
List date, place and surgery below:

Hospitalization

Have you ever been in the hospital for a medical illness? ☐
List date, place and illness below:

Family Medical History

Has a close relative had a history of any of the following?		Relative
Breast Cancer	☐ Yes ☐ No	
Ovarian Cancer	☐ Yes ☐ No	
Colon Cancer	☐ Yes ☐ No	
Other Cancer (Type)	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
High Blood Pressure	☐ Yes ☐ No	
Heart Disease	☐ Yes ☐ No	
Stroke	☐ Yes ☐ No	
Tuberculosis	☐ Yes ☐ No	
Thyroid Disease	☐ Yes ☐ No	

Social History

Do you smoke? ☐ If so, how many packs per day?	Are you single, married, divorced, widowed? ☐
Do you drink alcohol? ☐ If so, how often?	Are you a victim of domestic violence? ☐
Do you use drugs? ☐	Occupation Employer
Are you in a relationship with someone of the ☐ opposite sex ☐ same sex ☐ both ☐ not sexually active	
Approximate number of lifetime sexual partners _____	

Menstrual

First day of last menstrual period	
Pain/Cramps? ☐ Normal ☐ Other	
Bleeding between periods ☐ Yes ☐ No	
Regular cycles? ☐ Yes ☐ No	
Period every days (i.e. 28 days)	
Total flow ☐ Light ☐ Medium ☐ Heavy	

Obstetrical

Total # of pregnancies	Total # of live births
Total # of abortions	Total # of miscarriages
Any cesarean sections? ☐ Yes ☐ No	
Any pregnancy complications? ☐ Yes ☐ No	
Please explain:	

Pharmacy

Name/ Location/ Phone Number

Name_____ Date of Birth _____ Date _____

Gynecology

Do you have a ***history*** of any of the following?			
Abnormal Pap Smears	☐ Yes	☐ No	When?
Pelvic Inflammatory Disease	☐ Yes	☐ No	When?
Sexually Transmitted Disease?	☐ Yes	☐ No	Which one(s)?
Fibrocystic Breast Condition?	☐ Yes	☐ No	
What is your method of contraception?			
If birth control pills, what kind?			Do you need refills of your birth control pills?
When was your last Pap smear?			Last Mammogram?
When was your last Bone Density?			Last Colonoscopy?

Review of Systems

Do you ***currently*** have any of these symptoms?					
Have you had recent weight loss/gain?	☐ Yes	☐ No	How many pounds?	Over how many months?	
What is your height			Do you feel you have had loss of height	☐ Yes	☐ No
Fever	☐ Yes	☐ No	Painful sex	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Hot flashes	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No	Vaginal discharge	☐ Yes	☐ No
Cough	☐ Yes	☐ No	Breast issues	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Depression/Anxiety	☐ Yes	☐ No
Abdominal Pain	☐ Yes	☐ No	Insomnia	☐ Yes	☐ No
Diarrhea/Constipation	☐ Yes	☐ No	Back pain	☐ Yes	☐ No
Heartburn/Bloating	☐ Yes	☐ No	Easy bruising	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No	Other:	☐ Yes	☐ No
Pain with Urination	☐ Yes	☐ No	Other:	☐ Yes	☐ No
Urinary Incontinence	☐ Yes	☐ No	Other:	☐ Yes	☐ No
Painful periods	☐ Yes	☐ No			

Current Medications

Medication (including over the counter)	Dosage	How often?

Allergies

Are you allergic to latex?	☐ Yes	☐ No	
Are you allergic to any medications?	☐ Yes	☐ No	If so, please list:
Type of reaction (Example: rash, hives)			

Immunizations

If you are over 21 years old:	If you are over 65 years old:
When was your last Hepatitis B injection?	When was your last influenza injection?
When was your last Tetanus?	When was your last pneumococcal injection?

What is the reason for your visit today? _____

Please note: If your appointment today is for a "Well Woman Exam" and other problems or concerns are addressed, you may be charged an office visit in addition to the preventative visit which may generate an additional fee.

_____ _____

Patient/Guardian Signature Date