

Patient Name: _____ Age: _____ Date of Birth: _____ Today's Date: _____

Reason for today's visit: _____

Date of last period: _____ Age at onset of menses: _____ #days of menstrual bleeding: _____ Length of cycles: _____

Bleeding between periods: Yes No Pain with periods: Yes No Bleeding since menopause: Yes No

Contraception: Pills/ Ring IUD Tubal Ligation Vasectomy Other _____

Number of pregnancies: _____ Number of children: _____

Date of last pap: _____ Was it normal? Yes No Any abnormal paps? _____

Date of last mammogram: _____ Any abnormal mammograms? _____

Date of bone mineral density: _____

Date of colon cancer screen: _____

Allergies to Medications

<input type="checkbox"/> No Known Drug Allergies			
Drug:	<input type="checkbox"/> Asthma/Shortness of breath <input type="checkbox"/> Skin rashes/hives	<input type="checkbox"/> Nausea/vomiting/diarrhea <input type="checkbox"/> Anemia/blood disorder	<input type="checkbox"/> Shock/unconsciousness Other: _____
Drug:	<input type="checkbox"/> Asthma/Shortness of breath <input type="checkbox"/> Skin rashes/hives	<input type="checkbox"/> Nausea/vomiting/diarrhea <input type="checkbox"/> Anemia/blood disorder	<input type="checkbox"/> Shock/unconsciousness Other: _____

List Current Medications See attached list

Medical Problems

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Headaches
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> DVT (Blood Clots)	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Anemia

Other _____

List Surgeries

_____	_____
_____	_____
_____	_____
_____	_____

Family History

<input type="checkbox"/> Diabetes If yes, who: _____	<input type="checkbox"/> High blood pressure If yes, who: _____	<input type="checkbox"/> Thyroid Disease If yes, who: _____	<input type="checkbox"/> DVT (blood clots) If yes, who: _____	<input type="checkbox"/> Heart attack If yes, who: _____
<input type="checkbox"/> Ovarian cancer If yes, who: _____	<input type="checkbox"/> Breast cancer If yes, who: _____	<input type="checkbox"/> Colon cancer If yes, who: _____	<input type="checkbox"/> Osteoporosis If yes, who: _____	<input type="checkbox"/> Heart disease If yes, who: _____

Other _____

Patient Name _____

DOB _____

Social History

Do you smoke? Y N If yes, how much per day? _____ How many years have you smoked? _____

If you are a former smoker, what year did you quit? _____

Do you drink Alcohol? Y N Amount per week: _____

Do you use recreational drugs? Y N

Do you regularly exercise? Y N Amount per week: _____

Are you under a lot of pressure at work? Y N Type of Work: _____

Medical History (Are you having any issues with the following? Check all that apply.)

General Health:	<input type="checkbox"/> weight loss <input type="checkbox"/> weight gain <input type="checkbox"/> fever <input type="checkbox"/> fatigue Other: _____
Eyes:	<input type="checkbox"/> vision change <input type="checkbox"/> glaucoma <input type="checkbox"/> cataracts Other: _____
Mouth/Nose:	<input type="checkbox"/> ulcers <input type="checkbox"/> sinusitis <input type="checkbox"/> headaches Other: _____
Heart:	<input type="checkbox"/> chest pain <input type="checkbox"/> palpitations <input type="checkbox"/> difficulty breathing Other: _____
Respiratory	<input type="checkbox"/> wheezing <input type="checkbox"/> cough <input type="checkbox"/> sputum production Other: _____
GI:	<input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> excess gas Other: _____
Urinary:	<input type="checkbox"/> incontinent <input type="checkbox"/> urgency <input type="checkbox"/> frequency Other: _____
Muscle/Skeletal:	<input type="checkbox"/> weakness <input type="checkbox"/> joint pain Other: _____
Skin	<input type="checkbox"/> moles <input type="checkbox"/> rash Other: _____
Breasts:	<input type="checkbox"/> lumps <input type="checkbox"/> discharge <input type="checkbox"/> pain Other: _____
Neurologic:	<input type="checkbox"/> seizures <input type="checkbox"/> passing out <input type="checkbox"/> numbness Other: _____
Psychiatric:	<input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> obsessive Other: _____
Endocrine:	<input type="checkbox"/> weight issues <input type="checkbox"/> hot flashes <input type="checkbox"/> excess facial hair Other: _____
Heme/Lymph:	<input type="checkbox"/> swollen lymph nodes <input type="checkbox"/> easy bleeding Other: _____
Allergy Immune:	<input type="checkbox"/> _____