

NAME: _____

DATE: ___/___/___

REASON FOR VISIT: ROUTINE PHYSICAL PROBLEM DESCRIBE PROBLEM: _____

CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

MAJOR ILLNESSES	YES	DATE DIAGNOSED		YES	DATE DIAGNOSED
Anemia			Hepatitis		
Anxiety			High Blood Pressure		
Arthritis			Incontinence		
Asthma or other Pulmonary Issues			Kidney Infections		
Bleeding Disorder			Kidney Stones		
Blood Transfusion			Migraine Headaches		
Breast Disease			Osteoporosis		
Cancer			PCOS (Polycystic Ovarian Syndrome)		
Depression			Rheumatic Fever		
Diabetes			Sexually Transmitted Diseases		
Fracture			Stroke		
Frequent Urinary Tract Infections			Tuberculosis (TB)		
Heart Murmur			Thyroid Disease: Hypo / Hyper		
Heart Disease			Ulcers		

OTHER: _____

WHEN WAS YOUR LAST TEST OR IMMUNIZATION?

	DATE		DATE
When was your last pap smear?		Have you ever had a colonoscopy? Y N	
Have you ever had an abnormal pap? Y N		Have you had a bone density scan? Y N	
What treatment did you receive?		Have you ever had chickenpox? Y N	
When was your last mammogram?		Have you rec'd HPV/Gardasil immunizations?	

Other: _____

PLEASE LIST ANY PAST INJURIES OR ILLNESSES:

TYPE	DATE	TYPE	DATE

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

SURGERY / REASON	DATE	SURGERY / REASON	DATE

NAME: _____

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

DRUG NAME	DOSAGE	PHYSICIAN
ALLERGIES TO MEDICATIONS / SUBSTANCES (LATEX GLOVES, ETC.) ?	List:	Reaction:
List all "Natural" or Herbal remedies, over-the-counter drugs, vitamins or minerals you are taking	List:	

CHECK IF YOUR BLOOD RELATIVES HAVE HAD:

MAJOR ILLNESSES <input type="checkbox"/> Check here if you were adopted	None	Mother	Father	Brother	Sister	Grandmother (maternal)	Grandmother (paternal)	Grandfather (maternal)	Grandfather (paternal)	Uncle	Aunt
	Cancer: Breast, Ovarian or Colon										
Diabetes											
Heart Disease											
High Blood Pressure											
Osteoporosis											
Birth Defects											
Twins											

YOUR GYN HISTORY

Do you currently use birth control?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What type do you currently use?
<input type="checkbox"/> Condoms		<input type="checkbox"/> Nuvaring
<input type="checkbox"/> Depo Provera		<input type="checkbox"/> Birth Control Patch
<input type="checkbox"/> Diaphragm		<input type="checkbox"/> None
<input type="checkbox"/> IUD (Brand or Type):		<input type="checkbox"/> Natural Family Plan/Rhythm
– Date Inserted:		<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Birth Control Pill		<input type="checkbox"/> Vasectomy
– Name:		<input type="checkbox"/> Withdrawal
<input type="checkbox"/> Contraceptive Foam/Jelly		<input type="checkbox"/> Implanon
<input type="checkbox"/> Other:		– Date Inserted:
What age did you have your first period:		
How many days are there from start of period to start of next period: (days)		
How long does your period last? (days)	Flow:	<input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy
Number of Tampons per day:	Number of Pads per day:	
Date of Last Period:		
Do you have blood clots? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have spotting or bleeding between periods? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you often miss work/school due to your period? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have cramps? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have pain? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you gone thru Menopause: <input type="checkbox"/> Yes <input type="checkbox"/> No	At what age:	
Are you on Hormone Replacement Therapy (hormones)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

NAME: _____

YOUR OB HISTORY

	NUMBER	NUMBER
Total # of Pregnancies		Full -Term Births
Premature Births		Elective Abortions
Miscarriages		Living children
Ectopic Pregnancies		

On the chart below, please fill in answers for each pregnancy including abortions, miscarriages, and ectopics.

No.	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight/Sex	Del Type Vag/CSection	Epidural	Early Labor?	Wt Gain	Comments / Complications	Location
1				M F						
2				M F						
3				M F						
4				M F						
5				M F						
6				M F						

SOCIAL HISTORY

PLEASE LIST HABITS	
Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks per day: _____	Drink per week: _____
Caffeine <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks per day: _____	Drink per week: _____
Drug User <input type="checkbox"/> Yes <input type="checkbox"/> No Kind: _____	Frequency: _____
Smoking <input type="checkbox"/> Yes <input type="checkbox"/> No Packs per day: _____	Number of Years: _____
Have you ever been a smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Highest level of education completed: <input type="checkbox"/> High school <input type="checkbox"/> Some college <input type="checkbox"/> Associate's degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Post graduate degree <input type="checkbox"/> Trade school	
What is your occupation?	
Do you Exercise: <input type="checkbox"/> None <input type="checkbox"/> Once a week or less <input type="checkbox"/> 1-3 times a week <input type="checkbox"/> 4 or more times weekly	
History of abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Sexual	
Do you use Seat Belts? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Engaged <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Domestic partners	
Are you Sexually Active <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have sex with? <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both	