NAME: _____ DATE OF BIRTH: _____

REASON FOR YOUR VISIT: (If not Routine, briefly describe symptoms.) _____

_____

_____

PAST MEDICAL HISTORY: List all operations you have had and all illnesses you have had that required hospitalization.

	OPERATION	DATE		ILLNESS	DATE
A.	_____	_____	A.	_____	_____
B.	_____	_____	B.	_____	_____
C.	_____	_____	C.	_____	_____
D.	_____	_____	D.	_____	_____
E.	_____	_____	E.	_____	_____

Have you ever had? (Check YES or NO and give date)

YES	NO	ILLNESS	DATE
( )	( )	Migraine Headaches	_____
( )	( )	Thyroid Problems	_____
( )	( )	Tuberculosis	_____
( )	( )	Heart Murmur	_____
( )	( )	High Blood Pressure	_____
( )	( )	Rheumatic Fever	_____
( )	( )	Diabetes	_____
( )	( )	German Measles or Vaccine	_____
( )	( )	Anemia	_____
( )	( )	Convulsions or Seizures	_____
( )	( )	Ulcers	_____
( )	( )	Asthma	_____
( )	( )	Infertility	_____
( )	( )	Lupus	_____

YES	NO	ILLNESS	DATE
( )	( )	Jaundice or Hepatitis	_____
( )	( )	Kidney Stones	_____
( )	( )	Kidney Infection	_____
( )	( )	Bladder Infection	_____
( )	( )	Genital Herpes	_____
( )	( )	AIDS (HIV)	_____
( )	( )	Gonorrhea	_____
( )	( )	Syphilis	_____
( )	( )	Broken Bones	_____
( )	( )	Arthritis	_____
( )	( )	Liver Disease	_____
( )	( )	High Cholesterol	_____
( )	( )	Cancer	_____
( )	( )	Genital Warts	_____
( )	( )	Chalmydia	_____

REVIEW OF SYSTEMS:

YES	NO	GENERAL
( )	( )	Recent Weight Gain
( )	( )	Recent Weight Loss
( )	( )	Depression
( )	( )	Headaches
( )	( )	Eye Pain
( )	( )	Spots in Front of Eyes
( )	( )	Double Vision
( )	( )	Glasses
( )	( )	Deafness
( )	( )	Nose Bleeds
( )	( )	Sexual Abuse or Domestic Violence

YES	NO	CHEST and HEART
( )	( )	Heart Disease
( )	( )	Palpitation
( )	( )	Skipped or Irregular Heart Beats
( )	( )	Chest Discomforts on Exertion
( )	( )	Chest Pain with Breathing
( )	( )	Short of Breath with Exertion
( )	( )	Awaking at Night Short of Breath
( )	( )	Short of Breath Lying Down
( )	( )	Coughing Up Blood

YES	NO	BREASTS
( )	( )	Breast Lump
( )	( )	Breast Tenderness
( )	( )	Nipple Discharge
( )	( )	Family History of Breast Cancer
( )	( )	Perform Self Breast Exams
( )	( )	Previous Mammogram Date: _____

YES	NO	GASTROINTESTINAL
( )	( )	Nausea or Vomiting
( )	( )	Change of Bowel Habits
( )	( )	Painful Bowel Movements
( )	( )	Constipation
( )	( )	Diarrhea
( )	( )	Bright Red Blood in Stools
( )	( )	Clay Colored Stools
( )	( )	Abdominal Pain
( )	( )	Hemorrhoids
( )	( )	Vomiting up Blood

YES	NO	GENITO-URINARY
( )	( )	Frequent or Painful Urination
( )	( )	Difficulty Holding Urine
( )	( )	Difficulty Starting Urine
( )	( )	Excessive Urine
( )	( )	Frequent Night Urination
( )	( )	Change in Color of Urine
( )	( )	Blood or Pus in Urine
( )	( )	Wetting in Bed

YES	NO	EXTREMITIES
( )	( )	Varicose Veins
( )	( )	Pain in Legs When Walking
( )	( )	Blood Clots in Legs
( )	( )	Skin Rashes
( )	( )	New or Growing Moles
( )	( )	Increased Body Hair
( )	( )	Decreased Body Hair
( )	( )	Increased Skin Pigmentation

NAME: _____ ID# _____

MEDICATIONS: **List ALL medications that you take regularly or have taken recently, include all non-prescription drugs.**

1) _____ 3) _____

2) _____ 4) _____

ALLERGIES: **Are you allergic to any medications, drugs, chemicals or food? If, YES, list which ones.**

_____

CONTRACEPTIVE HISTORY: **List present and previous history of birth control you have used.**

	TYPE OF METHOD	DURATION OF USE	COMPLICATIONS
PRESENT	_____	_____	_____
PREVIOUS	_____	_____	_____

(- IUD - DIAPHRAGM - NORPLANT - SPONGE - SPERMICIDE - CONDOMS - DEPO -)

OBSTETRICS HISTORY : **List all pregnancies, date, and outcomes.**

	DATE	SEX	WEIGHT	LABOR # Hrs.	DEL / TYPE	ANESTHESIA TYPE	COMPLICATIONS
1.	____	M / F	_____	_____	_____	_____	_____
2.	____	M / F	_____	_____	_____	_____	_____
3.	____	M / F	_____	_____	_____	_____	_____
4.	____	M / F	_____	_____	_____	_____	_____
5.	____	M / F	_____	_____	_____	_____	_____
6.	____	M / F	_____	_____	_____	_____	_____

FAMILY HISTORY: **(List Family Members (Father, Mother, Sister, Brother) with any current problems and their age. Also, list deceased Family Members, the cause and age at the time of their death.**

_____

_____

Have any other blood relatives had serious medical problems or inherited problems? Any children born in the family with an abnormality?

_____

SOCIAL HISTORY:

Do you use street drugs?	YES / NO	Amount / Day? _____	Type? _____
Do you smoke cigarettes?	YES / NO	Amount / Day? _____	# of Years? _____
Do you drink Alcohol?	YES / NO	Amount / Day? _____	Per Week? _____
Do you drink Caffeine?	YES / NO	Amount / Day? _____	Type? _____
Do you get any regular exercise?	YES / NO	Amount / Day? _____	Type? _____

MENSTRUAL HISTORY:

Age first started period: _____ First day of last period: _____ Usual number of days from one period to next: _____
Number of days of flow: _____ Are your periods : Light _____ Moderate _____ Heavy _____
Any excessive bleeding or spotting between cycles? YES / NO Cramps with period? YES / NO
Depression, anxiety, emotional upset before your period starts? _____

PAP SMEARS:

Last pelvic exam: _____ Last pap smear: _____ Have you ever had an abnormal pap? YES / NO
Did your mother take hormones while pregnant with you? YES / NO

VAGINITIS:

Have you ever had Yeast? YES / NO Trichomonas? YES / NO Non Specific / Gardenerelle Vaginitis? YES / NO
Are you having any problems with discharge now? YES / NO

SEXUAL HISTORY:

Are you sexually active? YES / NO One partner? YES / NO Multiple partners? YES / NO How many partners to date? _____
Any problems with pain? YES / NO Orgasm: YES / NO Other: _____