



MEDICAL HISTORY CONTINUED

Medical History

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Cancer
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Clotting/Bleeding Disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Herpes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Lupus	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Recurrent UTIs or Interstitial Cystitis
<input type="checkbox"/> Stomach Issues	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Disorders	<input type="checkbox"/> Varicose Veins	

Childhood diseases such as German measles or chicken pox:

Other/Specify:

Preferred Pharmacy:

MENTAL/EMOTIONAL

Do you experience or have history of any of the following

Depression Anxiety ADHD Eating Disorders Other Behavioral Conditions

If yes, please put dates (past/current), and treatments (past/current)

Any current or past history of physical abuse? Yes No Or sexual abuse? Yes No

DIET/EXERCISE

Dietary preferences/restrictions:

What do you like to do for exercise?

How often do you exercise?

For how many minutes?

SOCIAL HISTORY

Tobacco use: Yes No How much? How long?

When did you quit (if applicable)?

Caffeine use: Yes No How much? How long?

When did you quit (if applicable)?

Alcohol use: Yes No How much? How long?

When did you quit (if applicable)?

Marijuana use: Yes No How much? How long?

When did you quit (if applicable)?

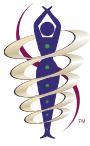
Other drug use? Yes No What? How long?

When did you quit (if applicable)?

Are you currently employed? Yes No

Do you currently have housing? Yes No

Do you have difficulty affording food, clothing, or housing? Yes No



LIFE STRESSES

Family, work, self, etc.

FAMILY HISTORY

Please include diseases, age of person if alive and age/cause of death if deceased.

Mother:	Father:
Sisters:	Brothers:
Maternal Grandmother:	Maternal Grandfather:
Paternal Grandmother:	Paternal Grandfather:
Aunts:	Uncles:
Children:	
Other:	

GYNECOLOGICAL HISTORY

First day of last period: _____

Date of last PAP smear: _____ Date of last pelvic exam: _____

Have you EVER had an abnormal PAP? Yes No When? _____ Results? _____

Treatment? _____

Age first period began: _____

Have you had the HPV vaccine? Yes No If yes, when? _____

Normally (not on pills) how many days from the start of one period to the start of the next? _____

Number of days of flow: _____ Bleeding amount? _____ Cramping Amount: _____

Do you have a history of infertility? Yes No If yes, please describe: _____

Have you ever had any history of sexually transmitted infections? Yes No

If yes, please describe: _____

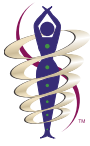
REVIEW OF SYSTEMS: ANY PRESENT PROBLEMS YOU ARE EXPERIENCING (CIRCLE)

General

Fever Chills Hot flashes Unusual hair growth
Skin eruptions Weight Change

Head

Headaches Dizziness Visual changes Hearing defects
Sinus trouble Fainting



REVIEW OF SYSTEMS CONT: ANY PRESENT PROBLEMS YOU ARE EXPERIENCING (CIRCLE)

Abdomen

Bloating Heartburn/indigestion Cramps/pain Nausea/vomiting
Diarrhea Constipation Hemorrhoids Bloody/tarry stools

Chest

Chest pain Shortness of breath heart murmur MVP
Palpitations Chronic cough wheezing, Other:

Breasts

Lumps Bleeding Nipple discharge Tenderness, Other:

Bladder

Frequent urination Painful urination Blood in urine Inability to hold urine
Inability to empty bladder Need to get up at night to urinate
Other concerns:

CURRENT HEALTH CARE PROVIDERS

Current Health Care Providers:

Would any of these healthcare providers prefer us to follow-up after your visit here?

Name:

Address:

AUTHORIZATION:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for all service rendered on my dependents or my behalf. I consent to/and authorize treatment for the above named patient. I authorize the release of any information requested by health professionals participating in my care.

Name:

Signature:

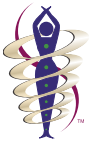
Date:

How did you hear about us?

Online search? Friend? What were the keywords you searched?

Website? Friend? Who may we thank?

Other?



GYN ADDITIONAL QUESTIONS

Do you experience premenstrual symptoms? Yes No When do they start? _____

Are there any current changes to your normal pattern? Yes No _____

Bleeding between periods? _____ When? _____

Unusual pelvic pain or fullness? _____ When & describe: _____

How long has this occurred? _____ Treatments you have tried? _____

Past history of tubal infection? Yes No

Other: _____

Have you ever had a mammogram? Yes No Date: _____

Do you do self-breast exams? Yes No

SEXUAL HISTORY

Are you sexually active? Yes No

How many partners have you had in the past year? _____

Do you have male partners, female partners, or both? _____

Are you trying to get pregnant? Yes No

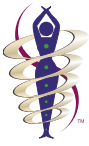
For how long have you tried? _____

Current birth control method: _____ How long? _____

Past birth control methods: _____

Problems experienced with any birth control methods: _____

Any sexual concerns to discuss? _____



OB ADDITIONAL QUESTIONS

SOCIAL HISTORY/EXPOSURE:

Was this a planned pregnancy? Yes No

Spouse/Partner's name: _____

Do you have any religious objectives to any form of medical treatment that you would like to make us aware of (i.e. refusal of blood transfusions)? Yes No If so, please elaborate: _____

Do you have cats? Yes No

If yes, do you handle the litter box? _____

Please list any sources of chemical or radiation exposure that you encounter: _____

Did you use any assisted reproductive technology to become pregnant? (Ex: IUI, IVF, etc) _____

If yes please describe and note fertility specialist _____

GENETIC HISTORY:

Will you be 35 or older at the time the baby is born? Yes No

Will the father/sperm donor be 50 or older? Yes No

Have either you or the baby's father had a child born with a birth defect? Yes No

If yes, please describe: _____

Did either you or the baby's father have a birth defect yourselves? Yes No

If yes, please describe: _____

Please describe any abnormalities that have occurred in children in your family or the baby's family (for example Down Syndrome, birth defects, deformities, or inherited diseases like hemophilia, muscular dystrophy or cystic fibrosis). _____

How is the affected child/person related to you? _____

Do either you have a history of pregnancy losses (miscarriages or stillborn)? Yes No

Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please circle if either you or the baby's father/sperm donor is one of these backgrounds:

Jewish ancestry? Yes No If yes, have you had Tay-Sachs screening tests? Yes No

Date: _____ Result: _____

African-American? Yes No If yes, have you had Sickle Cell screening? Yes No

Date: _____ Result: _____

Do you or the baby's father/sperm donor have a history of twins/ multiple babies? Yes No

If yes, who? _____

Please list any other concerns you have about birth defects or inherited disorders: _____