Date:_____

Name: (First and Last)_____ **Date of Birth**: _____

Is there a phone number where we can leave confidential messages such as test results/ special instructions for today's visit as well as for future visits? Phone number: _____

Emergency Contact Name: **Phone:** _____

Pharmacy Name and phone number: _____

Reason for Visit: _____

Past or Current Medical Problems:

Diabetes	Yes	No	Lung Problems	Yes	No
High Blood Pressure	Yes	No	Breast Problems	Yes	No
Heart Disease	Yes	No	Rheumatoid Arthritis, lupus	Yes	No
Autoimmune Disease	Yes	No	Urinary Incontinence	Yes	No
Kidney or Bladder disease	Yes	No	Uterine Abnormalities	Yes	No
Neurologic disorders	Yes	No	Migraines	Yes	No
Psychiatric Problem	Yes	No	Anxiety, Panic Attacks	Yes	No
Depression/post postpartum depression	Yes	No	Herpes	Yes	No
Hepatitis/Liver disease	Yes	No	Anemia, Blood Disorder	Yes	No
Varicose Veins, Blood clots	Yes	No	Allergies, Hay Fever	Yes	No
Trauma/Violence	Yes	No	Infertility	Yes	No
Thyroid Disorder	Yes	No	Sexually Transmitted disease	Yes	No
Blood Transfusion	Yes	No	Abnormal Pap	Yes	No
Chicken Pox	Yes	No	HIV	Yes	No

If yes to any of the above please explain: _____

_____

_____

Surgeries and approximate dates (Month/Year): _____

_____

Immediate Family Members who have:

Diabetes: _____
High Blood Pressure/Heart Disease: _____
High Cholesterol: _____
Substance Abuse: _____
Dementia/Alzheimer's: _____
Other: _____

Colon Cancer: _____
Prostate Cancer: _____
Thyroid Cancer: _____
Breast/Ovarian Cancer: _____
Depression: _____

Social History:

Do you smoke?_____ How much?_____ Past Smoker?_____ Quit (month and year) _____
Do you drink alcohol? _____ How many drinks per week? _____ Do you use recreational drugs?_____
If Yes what drugs_____ Current Birth control method?_____ If you have a partner have they ever threatened or harmed you? _____ What is your current occupation? _____
What is your current marital status?_____ Sexual Orientation:_____
Highest level of education received:_____ Do you exercise, and how often?_____

Obstetric History:

Pregnancies_____ # Deliveries_____ # Abortions_____ # Miscarriages_____ # Ectopics_____
First day of most recent period:_____

GYN History

Date of last normal period?_____ How many days do you bleed?_____
Are your periods painful or heavy?_____ Are your periods regular?_____
Do you bleed in between periods? _____ Do you get hot flashes?_____ night sweats?_____
How often are your periods?_____ Have you ever had intercourse?_____
Are you having pain with intercourse?_____ Do you ever have bleeding after intercourse?_____

Pregnancies: (outcome is vaginal delivery, cesarean, miscarriage, abortion or ectopic

Date	Outcome	Weeks	Living	Hours in Labor	Weight	Sex	Name

Health Care Maintenance Tests: (month/year)

Last Pap Smear: _____ Last Mammogram: _____ Diagnostic or screening?

Last DEXA scan: _____ Last Colonoscopy: _____

Medication Allergies and Reaction:
_____

Current Medications (include over the counter): Please include dose and amount taken per day

_____ _____ _____

_____ _____ _____