Name____

The following information assists us in providing you the most excellent care. **Please fill out both sides of this form completely.**

Have you ever had any of the following (circle all that apply)?

Abnormal pap smear	Depression	Heart Disease	Mitral Valve Prolapse
Anemia	Diabetes	Hemorroids	Osteoporosis
Anxiety	DVT	Hepatitis	Problem with Anesthesia
Arthritis	Emphysema	HIV/AIDS	Rheumatic Fever
Asthma	Epilepsy	High Cholesterol	Stroke
Bipolar Disorder	Frequent Bladder Infections	High Blood Pressure	Lupus
Blood Transfusion	Gastric Ulcer	Irritable Bowel	Thyroid Disease
Chlamydia	Genetic Carrier	Kidney Stone	Cancer- if Yes then what kind
Clotting Disorder	Genital Herpes	Kidney Disease	Other(List):
Condyloma (Genital Warts)	GERD	Liver Disease	**MRSA**
Congenital Birth Defect	Gonorrhea	Migraines	None

Your most recent:	**Date**	**Result**	**Your most recent:**	**Date**	**Result**
Mammogram			Cholesterol Check		
PAP Smear			Bone Density Scan		

List all Surgeries and Procedures

Type	Year Performed	Type	Year performed

List all prescription and over-the-counter medications and supplements you take regularly

Medication	Dose	Frequency (how often)	Prescribing Physician (or over-the-counter)

List all medication allergies and the reaction you have if you take them

Allergic to:	Reaction	Allergic to:	Reaction

Family History If you are adopted and blood relative history is unknown, proceed to page 2.
Indicate "M" for maternal or "P" for paternal family member

Problem	Relationship	Age Onset	Problem	Relationship	Age Onset
Anemia			Epilepsy		
Asthma			Heart Disease		
Blood Disorder			High Cholesterol		
Blood Clots			Hypertension		

Cancer-indicate kind			Kidney Disease		
Depression			Migraines		
Diabetes Type I			Stroke		
Diabetes TypeII			Thyroid Disease		
Depression			Other		

Gynecologic History

Age of first menstruation:_______

How many days do your periods last?________

Menopause NO YES, since age_______

Length of menstrual cycle_______

First day of most recent menstrual period:__________

Do you bleed or spot between periods? NO YES

Sexually active YES___ No____

If YES, sexual preference Men__ Women____ E Both____

Current Birth Control Method (circle all that apply)

Virgin	Natural Family Planning	Foam/Gel	Pill	Vasectomy
Abstinent	Withdrawal	Diaphragm	Nuvaring	Tubal Ligation
None	Condoms	IUD	Depo-Provera	Hysterectomy

Obstetric History

Date of Delivery, Miscarriage, or abortion	Weight	Sex of baby	Vaginal or C-section?	Location/Doctor	Complications

Social History (circle the appropriat answer)

Marital status:	Single	Engaged	Married	Divorced	Widowed
Do you smoke?	Never	Former-Quit when?			Yes-How many per day?
Do you drink alcohol?	Never	Yes-How much and how often?			
Do you use illegal drugs?	Never	Yes-How much and how often and what kind?			
Do you drink caffeine?	No	Yes-What kind and how often?			
How much exercise do you get?		Sedentary	1-2 times/mo	1-2 times/wk	3-4 times/wk daily
Do you perform monthly breast self-exams?			Never	Sometimes	Always

Please circle any symptoms you are currently having:

Weight gain	Varicose Veins	Urinary frequency	New skin lesions	Difficulty sleeping
Weight loss	Diarrhea	Urinary urgency	Changes in moles	Swollen lymph nods
Chronic fatigue	Constipation	Leaking urine	Hot flashes	Seasonal allergies
Persistent Fever	Abdominal Pain	Genital sores	Night sweats	
Frequent Headaches	Blood in stools	Vaginal discharge	Hair loss	
Breast Lumps	Fecal incontinence	Painful periods	Facial hair growth	
Nipple Discharge	Nightime urination	Irregular periods	Anxiety	
Lower Leg Swelling	Blood in urine	Vaginal odor	Depression	