NAME _____ AGE _____Date of Birth _____

Explain the reason you are seeing the doctor today _____

_____

Primary Care Physician _____

If you are a new patient – how did you hear of our practice? Friend/Relative, TV Phonebook, Newspaper, Referral, Other _____

GYN HISTORY

1. Have you ever been pregnant? Yes or No What was your age at your first delivery? _____
   If yes, how many times? _____
   How many vaginal deliveries? _____ C-Sections _____ Miscarriages _____ Terminations _____
   Tubal/Ectopic _____
2. Have you ever had an abnormal pap? Yes or No
   If yes, how was it treated? _____
3. Have you ever had a pelvic infection (PID)? Yes or No
4. Do you ever have any leaking of urine? Yes or No
5. Do you have pain with intercourse? Yes or No
6. Do you have any abnormal vaginal discharge? Yes or No
7. How often do you do self-breast exams? _____
8. Have you had any breast biopsies? Yes or No If yes, how many _____
9. Do you have a history of atypical hyperplasia of the breast? _____
10. **Date of last mammogram** _____ **Date of last pap** _____
11. Do you know if you are immune to rubella (German Measles)? _____
12. What type of birth control do you use? _____
13. Are you currently or have you ever been sexually active? Yes or No
14. Optional – Please list sexual orientation _____
15. Are you or have you ever been physically, emotionally, or sexually abused? _____

Medical Tests/History

1. Have you ever had a Dexa scan? Yes or No If yes, When _____
2. Have you ever had a colonoscopy? Yes or No If yes, When _____
3. Have you ever had a fracture? Yes or No If yes, where and when _____
4. Have you had the Gardasil vaccination series? Yes or No

MENSTRUAL HISTORY

1. Age of first period _____
   a. **First day of last period _____ Update _____ Update _____**
   b. How often does period come _____ How long does it last _____
   c. Do you have pain with your period? _____
2. Age at menopause ____ (If you are not menopausal, skip down to surgical history)
   a. Do you have any postmenopausal symptoms? _____
   b. Any bleeding? _____

PATIENT SURGICAL HISTORY

Please list any surgeries you have had:

_____

_____

_____

MEDICATIONS

Please list any medications you are currently taking (including birth control/vasectomy/tubal): (and dose if known)

_____

_____

ALLERGIES

Please list any allergies or reactions that you have (**especially latex or silicone**):

UPDATE_____

PAST MEDICAL HISTORY

Do you currently have or have you ever had: (circle yes or no)

High Blood Pressure	Yes	No	If yes, please explain _____
Heart Disease	Yes	No	If yes, please explain _____
Heart Murmur	Yes	No	If yes, please explain _____
Rheumatic Fever	Yes	No	If yes, please explain _____
Diabetes	Yes	No	If yes, please explain _____
Lung Disease	Yes	No	If yes, please explain _____
COPD (Lung Disease)	Yes	No	If yes, please explain _____
Emphysema	Yes	No	If yes, please explain _____
Asthma	Yes	No	If yes, please explain _____
Kidney Disease	Yes	No	If yes, please explain _____
Urinary Tract Problem	Yes	No	If yes, please explain _____
Seizures	Yes	No	If yes, please explain _____
Neurologic Disease example: Multiple Sclerosis	Yes	No	If yes, please explain _____
Psychiatric Illness	Yes	No	If yes, please explain _____
Cancer	Yes	No	If yes, please explain _____
Thrombosis/Embolism (Blood Clots)	Yes	No	If yes, please explain _____
Hepatitis	Yes	No	If yes, please explain _____
Liver Disease	Yes	No	If yes, please explain _____
Anemia	Yes	No	If yes, please explain _____
Blood Disorders	Yes	No	If yes, please explain _____
Osteoporosis	Yes	No	If yes, please explain _____
Stroke	Yes	No	If yes, please explain _____
Thyroid Disorder	Yes	No	If yes, please explain _____
Breast lump/problem	Yes	No	If yes, please explain _____
Other (please list)	Yes	No	If yes, please explain _____

Have you ever been told you have or have had MRSA (methicillin resistant infection)? Yes No

FAMILY HISTORY

Has anyone in your family ever been diagnosed with: (circle yes or no)

Heart Disease	Yes	No	If yes, please explain _____
Diabetes	Yes	No	If yes, please explain _____
Osteoporosis	Yes	No	If yes, please explain _____
Stroke or Deep Vein Thrombosis (Clotting Disorder)	Yes	No	If yes, please explain _____
Breast Cancer	Yes	No	If yes, please explain _____
Colon Cancer	Yes	No	If yes, please explain _____
Ovarian Cancer	Yes	No	If yes, please explain _____
Uterine Cancer	Yes	No	If yes, please explain _____
Cervical Cancer	Yes	No	If yes, please explain _____
Other Cancer	Yes	No	If yes, please explain _____
Birth Defects	Yes	No	If yes, please explain _____
Cystic Fibrosis (Lung Disease)	Yes	No	If yes, please explain _____
Muscular Dystrophy	Yes	No	If yes, please explain _____
Tay Sachs Disease	Yes	No	If yes, please explain _____

SOCIAL HISTORY

Are You: Married Single Divorced Widowed Separated

Occupation: _____ Full-time Part-time Retired

Do you smoke? Yes or No How Many Years _____

Have you tried to stop? Yes or No How many per day _____

Do you drink alcoholic beverages? Yes or No How much per week _____

Do you use recreational drugs? Yes or No

(marijuana, cocaine, other)

DIET/EXERCISE

Any diet restrictions? Yes or No If yes, what type _____

What type of exercise do you do and how often? _____

_____

_____

Have you ever had your cholesterol tested? _____ Date done _____

REVIEW OF SYMPTOMS

Have you experienced any of the following symptoms within the past year? (Check all that apply)

		UPDATE
____	Unexplained fever, weight loss, weight gain	_____
____	Loss of vision, other visual disturbance	_____
____	Ringing in ears, nose bleeds, difficulty swallowing	_____
____	Chest pain, shortness of breath, palpitations	_____
____	Wheezing, difficulty breathing, chronic cough	_____
____	Change in bowel habits, blood in stool, chronic diarrhea	_____
____	Muscle weakness, joint pain	_____
____	Skin rashes, breast lumps, breast discharge	_____
____	Headaches, numbness	_____
____	Depression, sleeping difficulties	_____
____	Blood in urine or pain with urination	_____

If we need to contact you where do you prefer we call? Please fill in all that apply:

Home # _____ Work # _____

Other (cell phone, message phone, etc. – please explain) _____

Please list any person(s) you want information regarding your care released to _____

_____ _____

Signature Date

- **UPDATED (SIGN AND DATE) _____**

IF YOU ARE MORE THAN 10 MINUTES LATE FOR YOUR APPOINTMENT YOU WILL HAVE TO RESCHEDULE.

YOU MUST CHECK WITH YOUR INSURANCE FOR COVERAGE/PAYMENT FOR THIS VISIT. **(5-13-14 update)**