

(Please fill out all information to the best of your ability)

Date: _____

Patient's Name: _____ DOB: ____/____/____ Age: _____ Race: _____

Referred by: _____ Primary Care Physician: _____

Reason for Appt: _____ Pharmacy: _____
(Local and Mail Order)

Allergy/Reaction: _____
(Please list anything you are allergic to and the reaction it causes.)

Medication & Dosage: _____

Past Medical History: Have you ever had any of the following illnesses? Circle Yes or No.

- | | |
|---|--|
| Y N Have you ever had a blood transfusion? | Y N Are you willing to have a blood transfusion to save your life? |
| Y N Ever had an abnormal Pap Smear? If yes, treatment _____ | Year: _____ |
| Y N Heart Trouble | Y N Osteoporosis |
| Y N Kidney/Bladder Problem | Y N Fibroids |
| Y N High Blood Pressure | Y N Pelvic Prolapse |
| Y N Low Blood Pressure | Y N Depression |
| Y N Thyroid Problem | Y N Endometriosis |
| Y N Rectal Bleeding | Y N Seizures |
| Y N Stomach Trouble | Y N Anemia |
| Y N IBS | Y N High Cholesterol |
| Y N Ulcer | Y N Anxiety |
| Y N Diabetes | Y N Blood Disorders |
| Y N Breast Discharge/Problem | Y N Hemorrhoids |
| Y N Anesthesia Problems | Y N Heart Murmur/MVP |
| Y N Antibiotic for dental work | Y N Polycystic Ovarian Syndrome |
| Y N Chlamydia | Y N Gonorrhea |
| Y N Hepatitis | Y N HIV |
| Y N Genital Herpes | Y N Genital Warts |
| Y N Syphilis | Y N HPV |
- Cancer: _____

Surgical History: Please list all surgeries including hospitalizations (not related to pregnancy).

Date	Procedure

Pregnancy History: Please list all pregnancies (including ectopic/miscarriage/abortion).

Date	Delivery Type (vaginal/cesarean)	Sex	Lbs/Oz	Complications

Family History: Please list illnesses of these family members: children/mother/father/siblings/grandparents

Cancer Type	Family Member/Age	Y N Heart Disease. Who? _____
Y N Breast Cancer		Y N High Blood Pressure. Who? _____
Y N Uterine Cancer		Y N High Cholesterol. Who? _____
Y N Skin Cancer		Y N Blood Disorder. Who? _____
Y N Ovarian Cancer		Y N Diabetes. Who? _____
Y N Colon Cancer		Y N Thyroid Disease. Who? _____

Other Significant Family History: _____

Social History

Use of alcohol: **Never/Daily/Moderate** Use of tobacco: Y N _____ packs per day Use of drugs: Y N
Hx of domestic violence: Y N Sexually active: Y N Birth control method: _____

Last Pap: _____ Last Mammogram: _____ Last Bone Density: _____ Last Colonoscopy: _____
date date date date