

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

Patient's Name: _____ Marital Status: _____ 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.)

Medications & Dosages: _____

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(s): _____ | |
| Y N Heart Trouble | Y N Osteoporosis |
| Y N Kidney/Bladder Problems
-or- Urinary Incontinence | Y N Fibroids |
| Y N High or Low Blood Pressure | Y N Pelvic Prolapse |
| Y N Migraine Headaches | Y N Depression/Anxiety |
| Y N Thyroid Problem | Y N Endometriosis |
| Y N Rectal Bleeding | Y N Seizures |
| Y N Ulcer | Y N Anemia |
| Y N IBS | Y N High Cholesterol |
| Y N Infertility | Y N Anxiety |
| Y N Diabetes | Y N Bleeding Disorders/Blood Clots |
| Y N Gonorrhea/Chlamydia | Y N Hepatitis |
| Y N HIV | Y N Herpes |
| Y N Genital Warts | Y N Syphilis |
| Y N HPV | Y N Abnormal Mammo |
| Y N Polycystic Ovarian Syndrome (PCOS) | Y N Ovarian Cysts |

History of Cancer: _____

Mo/Yr	ILLNESSES or OPERATIONS	Complications YES or NO

Obstetrical History
Please list the number of:

Premature Births _____ Miscarriages _____
Abortions _____ Times Pregnant _____
Living Children _____

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
Y N Breast Cancer		Y N High Blood Pressure
Y N Uterine Cancer		Y N High Cholesterol
Y N Skin Cancer		Y N Blood Disorder
Y N Ovarian Cancer		Y N Diabetes
Y N Colon Cancer		Y N Thyroid Disease

Other Significant Family History: _____

Social History

Use of alcohol: **Never/Daily/Moderate** Tobacco Use: Have you ever smoked? Y N
Drug use: Y N Current Smoker: _____ packs per day OR History of Domestic Violence: Y N
Former Smoker: quit date _____
LMP: _____ Sexually active: Y N Birth control method: _____
Date

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