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Name: _____ Name you prefer to be called? _____

Referred by: _____ **Primary Care Doctor**: _____

Please circle the reason for your visit today:

- Abnormal Radiologic Finding
- Abnormal Papsmear
- Annual Well Woman Exam
- Bleeding Problems
- Breast Symptoms
- Contraception Issues
- Menopause/Perimenopause Issue
- Menstrual Symptoms
- Pain: Abdominal/Pelvic
- Prolapse
- Urinary/Incontinence or Symptoms
- Vaginal/Vulvar Symptoms

Other/Please explain: _____

Gynecologic History:

Last menstrual period – date: _____

Age of first period: _____ Age of menopause: _____

Period Every _____ days. Lasts _____ days.

Heavy Periods? Cramps? PMS/Moodiness?

Night Sweats? Hot Flashes? Decreased Libido?

Sexually Active? Yes No Not Currently Never

Intercourse a problem? No Yes _____

Current Birth control method: _____

Hysterectomy? No Complete Partial Year _____ Age_____

Hormone Replacement Therapy? Never Short History Current

Obstetrical History:

Total pregnancies: _____

Full-term deliveries: _____

Preterm deliveries: _____ Weeks: _____

Miscarriages: _____ Abortions: _____

Ectopic/Tubal Pregnancies: _____

Twin Pregnancies: _____

Living Children: _____

Largest: _____lb _____ oz

C-Sections: _____

Complications: _____ None

Last Pap smear Date: _____ Abnormal Pap? Date: _____

Tx for Abnormal Pap: _____

Do you do regular Breast Self Exams? Yes No Occasionally

Last Mammogram date: _____

DEXA Bone density scan? No Yes Year _____ Results: Normal Osteoporosis Osteopenia

Screening Colonoscopy? No Yes Year _____ Results: Normal Polyps Diverticulosis Colon Cancer

Gardasil Vaccine? _____

Infection History (STD's) _____

Past Medical History:

- High Blood Pressure
- Heart Disease/Stents/Heart Valve
- Heart Attack/MI
- Congestive Heart Failure
- Diabetes
- Stroke/TIA
- GERD, Reflux
- Hypothyroidism/Hyperthyroidism
- High Cholesterol
- Diverticulosis/Diverticulitis
- Asthma or Chronic Bronchitis
- Kidney Stones
- Anxiety/Panic attacks
- Depression
- Breast Cancer
- Headaches
- Cataracts or Macular Degeneration
- Glaucoma
- Blood clotting disorder/DVT/PE
- Osteopenia/Osteoporosis

Other: _____

Surgical History: Please list all surgeries and biopsies that you have undergone:

Procedure	Date (year)	Procedure	Date (year)

Have you ever had any problems with anesthesia? ○ Yes ◉ No Had a Blood transfusion ○ Yes ◉ No

*****PLEASE COMPLETE BOTH SIDES OF THIS FORM *****

Name: _____

Medications: including vitamins, herbal and over the counter medications: **Allergies** to Medications

Medication and Dose	Medication and Dose	Allergies
1.	6.	
2.	7.	
3.	8.	
4.	9.	
5.	10.	No Know Drug Allergies ●
Pharmacy Name & Location:		Pharmacy # ( ) -

Are there any supplies that you get from a Home Health Company? (e.g. Glucose strips, cane walker, toilet….etc)

Family History:

Unknown Family History	What family relation	Age of death
High blood pressure		
Diabetes		
Heart Attack/Heart Problems		
Stroke		
Breast, Ovarian, Uterine, Cervical Cancer (circle)		
Other Cancer – Type _____		
Colon Cancer		
Depression/Anxiety		
Thyroid Disease		
Elevated Cholesterol		
Osteoporosis		
BLOOD CLOTTING DISORDER		
OTHER:		

Social History:

Are you: Single ☐ Engaged ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Long Term Relationship ☐

What is your diet like? _____Calcium per day? _____mg None Don't know

What is your occupation? _____Do you exercise? No ☐ Daily ☐ Regularly ☐ Occasionally ☐

Do you smoke cigarettes? Never smoked ☐ _____pack/s per day quit smoking _____(Year)

Do you drink alcohol? Never ☐ Rare ☐ Occasional _____drinks/wk Use any illicit drugs? Yes ☐ No ☐

Wear seat belts? Yes ☐ No ☐ Smoke detector? Yes ☐ No ☐ Immunizations up to date? Yes ☐ No ☐

Have you ever been abused? No ☐ Yes ☐ Physically ☐ Sexually ☐ Emotionally ☐ Verbally ☐ Safe now? Yes ☐ No ☐

Review of Systems: Please circle any other symptoms that you may be having:

☐ **General:** Weight gain, Weight loss, Fatigue, Loss of height

☐ **Eyes:** Vision changes, Blurring, Corrective lenses

☐ **Ears, Nose, Mouth, Throat:** Drainage, Discharge Hoarseness, Hearing problems, Vertigo

☐ **Cardiovascular**: Chest Pain, Leg pain with walking Shortness of breath with exertion, Leg swelling

☐ **Respiratory:** Wheezing, Cough, Sputum production

☐ **Gastrointestinal:** Nausea, Vomiting, Blood in stools, Change in stools, Diarrhea, Constipation, Pain with BM

☐ **Musculoskeletal:** Back pain, Arthritis, Weakness

☐ **Skin and/or Breast**: Rash, Change in moles, Breast lumps, Breast pain, Nipple Discharge

☐ **Neurologic:** Numbness, Dizziness, Headaches Difficulty walking, Fainting spells, Tremors

☐ **Psych:** Anxiety, Depression, Difficulty sleeping

☐ **Endocrine:** Hot/cold intolerance, Excessive thirst

☐ **Hematologic/Lymphatic**: Easy bruising, Swollen glands Anemia, Blood clotting disorder, Healing problems

☐ **Allergy**: Seasonal allergies, Steroid Use, Iodine, Latex

Other symptoms: _____

_____