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Name: _____ **Name you prefer to be called:** _____

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

Please select the reason for your visit today:

- ☐ Abnormal Radiologic Finding
- ☐ Abnormal Pap Smear
- ☐ 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. ☐ Regular ☐ Irregular
Periods: ☐ Heavy ☐ Cramps ☐ PMSMoodiness
Sx: ☐ Hot Flashes ☐ Night Sweats ☐ Low Libido
Sexually Active? ☐ Yes ☐ No ☐ Not Currently ☐ Never
Intercourse a problem? ☐ No ☐ Yes _____
Birth Control Method:_____
Hysterectomy? ☐ Yes ☐ No

Obstetrical History:

Total pregnancies: _____
Full-term deliveries: _____
Preterm deliveries: _____ Weeks: _____
Miscarriages: _____ Abortions: _____
Ectopic/Tubal Pregnancies: _____
Twin Pregnancies: _____
Living Children: _____
Largest: _____lb _____oz
Vaginal Deliveries: _____ C-Sections:_____
Complications: _____ None

Last PAP Smear Year: _____ --------> Have you ever had an abnormal PAP Smear? ☐ Yes ☐ No
Last Mammogram Year: _____ ---------> Have you ever had Breast Cancer? ☐ Yes ☐ No
DEXA Bone Density Scan Year: _____ ---------> Do you have a history of? ☐ Osteopenia ☐ Osteoporosis
Screening Colonoscopy Year: _____ ---------> Results: ☐ Normal ☐ Abnormal Family Hx Colon Cancer? ☐ Yes ☐ No
Gardasil Vaccine? ☐ Yes ☐ No Have you ever had a sexually transmitted infection? ☐ Yes ☐ No

Past Medical History (Have you ever had?)

- ☐ Anxiety
- ☐ Asthma/Chronic Bronchitis/COPD
- ☐ Atrial Fibrillation
- ☐ Blood clotting disorder/Blood Thinner
- ☐ Blood Transfusion
- ☐ Breast Cancer
- ☐ Chronic Kidney Disease
- ☐ Colon Cancer
- ☐ Congestive Heart Failure
- ☐ COVID Infection/COVID Vaccination
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis/Diverticulitis
- ☐ DVT/PE
- ☐ GERD/Reflux
- ☐ Glaucoma
- ☐ Heart Attack/Angina
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Stones
- ☐ Malignant Hyperthermia (Family Hx)
- ☐ Migraines
- ☐ MRSA Skin Infection
- ☐ Oxygen/Home Oxygen
- ☐ Panic Attacks
- ☐ Post-Operative Nausea/Vomiting
- ☐ Problems with Anesthesia
- ☐ PTSD
- ☐ Sleep Apnea/CPAP
- ☐ Stents/Heart Valve
- ☐ Stroke/TIA

Other: _____

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

Procedure	Year	Procedure	Year

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

Name: _____

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

Medication and Dose	Medication and Dose	MEDICATION ALLERGY
1.	7.	1.
2.	8.	2.
3.	9.	3.
4.	10.	4.
5.	11.	5.
6.	12.	**No Known Drug Allergies** ☐
Pharmacy Name & Location:		

Family History: Please select if you have a family history of the following

Condition	What Family Member/Relation	Age of Diagnosis	Age of Death
Breast/Ovarian/Uterine/Cervical Cancer			
Colon Cancer			
Other Cancer Type _____			
Blood Clotting Disorder			
Malignant Hyperthermia			
High Blood Pressure			
Elevated Cholesterol			
Coronary Artery Disease			
Diabetes			
CVA/Stroke			
Thyroid Disorders			
Other:			

Social History:

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

What is your occupation? _____ **If retired, previous occupation**? _____

What do you do for exercise/fun? _____ **How would you describe your diet**? _____

Do you smoke cigarettes/vape? ☐ Never _____pk/s per day **Quit Smoking** _____ (year) **Have you ever tried to quit**? ☐ Yes ☐ No

Do you use any illicit drugs? ☐ Yes ☐ No ☐ Never

Do you drink alcohol? ☐ Never ☐ Rare ☐ Occasional _____drink/s per wk **Do you have reliable transportation?** ☐ Yes ☐ No

Have you ever been abused? ☐ No ☐ Yes: ☐ Physically ☐ Sexually ☐ Emotionally ☐ Verbally **Are you safe now?** ☐ Yes ☐ No

Review of Systems:

Please select any other symptoms 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, Home O2

☐ **Gastrointestinal:** Nausea, Vomiting, Constipation, Diarrhea, Blood in stools, Change in stools, 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, Iodine, Latex; Steroid Use

Other Symptoms: _____