Name: _____ Date: _____

Reason for your visit: _____

Medical History

Allergies:

Are you allergic to any medication? Yes No Latex Allergy? Yes No

Name of Medication(s) Reaction: (rash, itching, shortness of breath, nausea, Etc.)

_____ _____

Medications: (List any medications you are presently taking including vitamins/supplements)

_____ _____

_____ _____

_____ _____

Social History:

Tobacco use currently: Yes No If yes, how much per day? _____

Tobacco use in the past: Yes No If yes, when did you stop smoking _____

Vaping: Yes No If yes, how much per day? _____

Alcohol use: Yes No If yes, how much per day/week _____

Street Drug use Yes No Marijuana Cocaine Methamphetamine Opioids Other: _____

Do you exercise regularly? Yes No Type of exercise? _____

Do you experience sleep problems? Yes No How often? _____

Marital Status(circle): Married Single Divorced Widowed Committed Relationship

Religious Affiliation (optional): _____

Personal Surgical History (Please give date):

Appendectomy_____ Gall Bladder _____

Breast Biopsy Left/Right_____ Heart Surgery (type) _____

Breast Reduction _____ Hysterectomy Vaginal/Abdominal _____

Breast Augmentation _____ LEEP/Conization _____

Colonoscopy (colon scope) _____ Removal of Ovaries _____

Name: _____ Date: _____

C-Section _____ (Indicate number) ____ Sterilization _____

Reason for C-Section_____

D & C _____ Tonsillectomy _____

Endometrial Ablation _____ Other _____

Personal Medical History: (Circle if applies)

Cancer (indicate type)

Breast
Cervical
Colon
Endometrial
Lung
Ovarian
Other _____

Gastrointestinal

Crohn's Disease
Ulcerative Colitis
Gallbladder Disease
GERD (Reflux)
Irritable Bowel Syndrome (IBS)
Liver Disease
Hepatitis
Ulcer

Infectious Disease

Chicken Pox
Shingles
HIV
Tuberculosis/Positive PPD
Rubella
Cytomegalovirus
MRSA

Pulmonary

Asthma
COPD/Emphysema
Seasonal Allergies

Rheumatology

Arthritis
Fibromyalgia
Lupus

Cardiovascular

High Blood Pressure
High Cholesterol
Heart Attack
Mitral Valve Prolapse
Rheumatic Fever
Varicosities

Hematology

Anemia
Blood Clotting Disorder
Blood Transfusion
DVT (Deep Vein Thrombosis)
PE (Pulmonary Embolism/ clot in lung)
Sickle Cell Disease/Trait

Neurology

Alzheimer's/Dementia
Headache/Migraines/Aura
Stroke
Epilepsy
Multiple Sclerosis

Urology

Frequent UTI (Urinary tract infection)
Hematuria (blood in urine)
Kidney Disease
Kidney Infection
Incontinence

Endocrinology

Diabetes Mellitus (during pregnancy)
Diabetes Mellitus (non-insulin dependent)
Diabetes Mellitus (insulin dependent)
Hypo/Hyper thyroid
Polycystic Ovarian Syndrome
Osteoporosis
Osteopenia

Psychiatric

ADD/ADHD
Anxiety
Bipolar
Depression
Eating Disorder
Panic Attacks

Obstetrical History:

Total # of Pregnancies? _____ Live full-term births? _____ Premature births? _____

Miscarriages? _____ Induced abortions? _____ Stillbirths? _____

Name: _____ Date: _____

Please list your pregnancies in order including miscarriages and abortions

Date	Hospital	Type of Delivery	Weeks	Infant Weight	Name	Sex	Complications
1.							
2.							
3.							
4.							
5.							

GYN History:

Date of most recent Pap Smear: _____ **Normal** **Abnormal** **Don't know**

Date of most recent Mammogram: _____ **Normal** **Abnormal** **Don't know**

Do you perform self-breast exams regularly? Yes No

Date of last Colonoscopy or Colon Cancer screening? _____

Date of most recent Bone Density: _____

History of: (Please circle all items that apply)

Abnormal Pap Smear	Ovarian Problems	Chlamydia	Group B Strep
Describe: _____	PCOS	Gonorrhea	HIV
HPV/Genital Warts	Infertility	Trichomonas	MRSA
Endometriosis	Bacterial Vaginosis	Herpes Simplex	
Fibroids	Yeast Infection	Syphilis	

Are you Sexually active? Yes No

Do you have sexual concerns to discuss with the provider today? Yes No

What is your sexual Orientation? Heterosexual Homosexual Bi-Sexual Other: _____

Current birth control method: _____ Number of lifetime sexual partners? _____

Are you happy with your method of birth control? Yes No

Menstrual History:

First day of last menstrual period: _____ Age started menstrual cycle: _____

If Menopausal, give year: _____

Name: _____ Date: _____

# of days of bleeding with your period: _____ # of days from start of one period to the start of the next _____

Flow is: Mild Moderate Heavy Menstrual Cramps: None Mild Moderate Severe

Bleed between periods: Yes No

Psychosocial History:

Do you feel safe at home and work?	Yes	No
Do you have someone to turn to for support?	Yes	No
Have you ever been forced into any sexual activity against your will?	Yes	No
Are you afraid of your partner or anyone else?	Yes	No

Immunization History: Have you been vaccinated for the following?

DPT	Yes	No	Chicken Pox	Yes	No	HPV	Yes	No
Polio	Yes	No	Influenza	Yes	No	(**If yes were all 3 doses received?)**		
MMR	Yes	No	Pneumonia	Yes	No	Dates: _____		
Hepatitis	Yes	No	Tetanus Booster	Yes	No			

Family Medical History: (Please indicate relationship: Mother, Father, Sister, Brother, Maternal/Paternal Grandmother, Etc.)

Are you adopted? Yes No

Has anyone in your family had any of the following health problems? If yes, give details?

Cancer	Yes	No	Whom: _____
High Cholesterol	Yes	No	Whom: _____
Osteoporosis	Yes	No	Whom: _____
Birth Defects	Yes	No	Whom: _____
Diabetes	Yes	No	Whom: _____
Diabetes in Pregnancy	Yes	No	Whom: _____
Hypertension	Yes	No	Whom: _____
Hypertension in Pregnancy	Yes	No	Whom: _____
Heart Disease	Yes	No	Whom: _____

Other: _____

Have you ever been tested for Hereditary Cancer? Yes No

Are you or your partner of Jewish Descent? Yes No

International travel this year? Yes No If yes when/where? _____

Do you have a Primary Care Provider? _____

Have you had any recent labs done elsewhere? _____