

Date: _____ Patient's Name: _____

Patient's Address: _____

Patient's Phone #: _____ Patient's Email address: _____

Medical Doctor's Name: _____ Medical Doctor's Phone #: _____

ALLERGIES:

Are you allergic to any medication: Yes No

Name of medication	Reaction: <i>(rash, itching, shortness of breath, nausea, etc.)</i>
_____	_____
_____	_____
_____	_____

IMMUNIZATIONS: *(Please provide the year the immunization was given)*

- | | |
|---|--|
| <input type="checkbox"/> Hepatitis B _____ | <input type="checkbox"/> Varicella (Chicken Pox) _____ |
| <input type="checkbox"/> Flu shot _____ | <input type="checkbox"/> Tetanus (DT) _____ |
| <input type="checkbox"/> Rubella (German Measles) _____ | |

MEDICATIONS: *(List any medications you are presently taking)*

FAMILY MEDICAL HISTORY: *(Please check any items pertinent to your relatives and provide relationship, i.e. Mother, Father, Sister, Brother, Grandparent)*

- | | |
|---|--|
| <input type="checkbox"/> Cancer (indicate type) _____ | <input type="checkbox"/> Irritable Bowel _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Osteopenia _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Endometriosis _____ | <input type="checkbox"/> Severe Menstrual Cramps _____ |
| <input type="checkbox"/> Fibrocystic Breasts _____ | <input type="checkbox"/> Stomach Ulcer _____ |
| <input type="checkbox"/> Fibroids _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Heart Attack _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Ulcerative Colitis _____ |
| <input type="checkbox"/> High Cholesterol _____ | |

Mother: Living Deceased @ age _____ Father: Living Deceased @ age _____

PERSONAL SURGICAL HISTORY: *(Check any surgical procedures you have undergone and list the date performed)*

- | | |
|--|---|
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Sterilization _____ |
| <input type="checkbox"/> Breast Biopsy Left/Right _____ | <input type="checkbox"/> Hysterectomy Vaginal/Abdominal _____ |
| <input type="checkbox"/> D & C _____ | <input type="checkbox"/> Laparoscopy _____ |
| <input type="checkbox"/> Breast Reduction _____ | <input type="checkbox"/> Tonsillectomy _____ |
| <input type="checkbox"/> Breast Augmentation _____ | <input type="checkbox"/> Gall Bladder _____ |
| <input type="checkbox"/> C-Section _____ (indicate number) _____ | <input type="checkbox"/> Other _____ |

PERSONAL MEDICAL HISTORY:

Provide date of last: Bone Density _____ Mammogram _____ Pap Smear _____ Colonoscopy _____

Type of Birth Control used at present time: _____

(Please check all items that apply)

- Abnormal Pap Smear (treatment) _____
- Anxiety
- Bipolar Disorder (Manic Depressive)
- Bladder Infections
- Cancer (indicate type) _____
- Chlamydia
- High Cholesterol
- Crohn's Disease
- Depression
- Diabetes Mellitus (Gestational)
- Diabetes Mellitus (Insulin Dependent)
- Diabetes Mellitus (Non-Insulin Dependent)
- DVT
- Endometriosis
- Fibrocystic Breast Disease
- Fibroids
- Gastric Ulcer
- GERD (Reflux)
- Gonorrhea
- Heart Attack
- Hepatitis
- Herpes
- Herpes Simplex
- HIV
- HPV (genital warts)
- Hypertension
- Hypothyroidism
- Irritable Bowel Syndrome
- Kidney Infections
- Migraine Headaches
- Mitral Valve Prolapse (antibiotics recommended)
- Mitral Valve Prolapse (no antibiotics recommended)
- Obsessive Compulsive Personality Disorder
- Osteopenia
- Osteoporosis
- Panic Attacks
- Phlebitis
- Postpartum Depression
- Schizophrenia
- Sickle Cell Disease
- Sickle Cell Trait
- Stroke
- Syphilis
- Trichomonal Vaginitis
- Ulcerative Colitis
- Recurrent Urinary Tract Infection
- Urologic Surgery
- Vaginosis - Bacterial
- Varicella (Chicken Pox)
- Yeast Infections

SOCIAL HISTORY:

Occupation: _____ Religious Affiliation: _____

Exercise: Inactive Light Moderate Heavy Vigorous

How much alcohol do you drink weekly: _____

Tobacco Use: Yes No Describe: _____

Drug Use: Yes No Describe: _____

PREGNANCY HISTORY:

How many times have you been pregnant: _____

How many living children: _____ Miscarriages: _____ Ectopic Pregnancies: _____

Any Complications: _____

MENSTRUAL HISTORY:

Date of Last Period: _____ # days of flow: _____ Flow is: mild moderate heavy

Menstrual Cramps: None Mild Moderate Severe # of pads/tampons used during heaviest day of flow: _____

Pain interferes with Lifestyle: Yes No Bleed between Periods: Yes No

Cycle Length: _____ (28-30 days, etc.) Age started menstrual cycle: _____