For office use only	
Height	
Weight	
BP	/

Patient Name:	Date of Birth: / /
Insurance:	

What is the reason for your visit today?____

MEDICATIONS AND ALLERGIES		
Please list any medications you are **currently taking**:		
Do you have any **allergies** to medications? If so, please list	No Yes	

MEDICAL HISTORY		
Are you currently being treated for **any medical conditions**? If so, please list:	No Yes	
Have you had any **past health problems**? If yes, please list:	No Yes	
Do you find little interest or little pleasure in doing things?	No	Yes
Do you feel depressed, down, or hopeless?	No	Yes

SURGICAL HX

HAVE YOU HAD ANY **SURGERIES**? **NO** **YES**	
DATE	SURGERY

HOSPITALIZATION HX

HAVE YOU BEEN **HOSPITALIZED** FOR ILLNESSES OTHER THAN SURGERIES OR CHILDBIRTH? **NO** **YES**	
DATE	REASON

FAMILY HISTORY

Do any of your **family members** have any of the following medical conditions?

	HEART DISEASE	HIGH BLOOD PRESSURE	DIABETES	THYROID DISORDERS	CANCER (LIST TYPE)	OSTEOPOROSIS	CLOTTING (DVT,PE)	OTHER
Father								
Mother								
Brother								
Sister								
Son								
Daughter								

Have any of your **immediate or extended family members** been diagnosed with any of the following cancers? No Yes

If yes, please circle:

Breast Ovarian Uterine/Endometrial Colon/Rectal

Melanoma Pancreatic Stomach/Gastric Brain Kidney Bladder Small bowel Sarcoma Thyroid

LAST UPDATED 11/2014

SOCIAL HISTORY					
Do you smoke?		No	Yes	Past	
If yes, how many cigarettes daily?					
Do you use street drugs?		No	Yes	Past	
Do you use alcohol?		No	Yes	Past	
If yes, how many drinks per week?					
Do you feel threatened or have you been a victim of abuse?		No	Yes	Past	
Do you have a regular exercise program?		No	Yes		
Marital Status:	Married	Single	Divorced	Engaged	Widowed

PREGNANCY HISTORY	
Total pregnancies	
Number of full term deliveries	
Number of preterm deliveries	
Number of induced abortions	
Number of miscarriages	
Ectopic pregnancies (tubal)	
Multiple births (ie twins)	
Living children	

GYN HISTORY

Do you still have menstrual periods?	No	Yes	Hysterectomy	Menopausal
What is the date of your last menstrual period?	/ /			
Are you currently using contraception? If yes, which form?	No	Yes	If yes, specify which form below:	
Birth control pills Condoms Depo Provera IUD Implanon/Nexplanon NFP Tubal Ligation vasectomy Other: **Sexual Orientation:**				
If you have periods, are your periods regular?	No	Yes		
How far apart? Lasting how long?				
What is the amount of bleeding that you have?	Spotting Light Moderate Heavy Clots			
Are your periods painful?	No Mild Moderate Severe			
How old were you when you had your first period?				
Are you currently sexually active?	No	Yes	Never active	
Lifetime number of sexual partners?				
Have you ever had a sexually transmitted disease?	No	Yes	If yes, please specify below::	
Chlamydia Gonorrhea Syphilis Genital warts HPV Herpes Trich				
Have you ever had an abnormal pap?	No	Yes		
Have you gone through menopause?	No	Yes	Hysterectomy	
Are you currently taking hormone replacement?	No	Yes	Past	
Date of last pap smear:	/ /	Normal	Abnormal	
Date of last mammogram:	/ /	Normal	Abnormal	
Date of last DEXA:	/ /	Normal	Abnormal	

CIRCLE ANY OF THE FOLLOWING PROBLEMS THAT APPLY TO YOU **CURRENTLY:**

fever, chills, or body aches
rashes or itching
concerning moles or lesions
vision changes
eye pain or discharge
ear pain or discharge
ringing in the ears
hearing difficulty
nasal congestion
sinus problems
loss of smell
sore throat
difficulty swallowing

shortness of breath
wheezing
cough or bloody sputum
heart palpitations
chest pain
loss of breath with exertion
leg swelling
abdominal pain or bloating
nausea or vomiting
diarrhea or constipation
bloody or dark black stools
painful urination
urinary frequency/urgency

joint, muscle or back pain
seizures, twitching or spasm
localized weakness/numbness
frequent headaches
fainting spells or dizziness
sleep difficulties
depression or anxiety
weight gain or loss
increased thirst
heat or cold intolerance
hot flashes
increased fatigue
changes in skin, hair, or nails

Other:____

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Height	
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BP	/

Patient Name:	Date of Birth: / /
Insurance:	

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Do you feel depressed, down, or hopeless?	No	Yes

SURGICAL HX

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DATE	SURGERY

HOSPITALIZATION HX

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