



Name _____

Date _____

Primary Care Physician _____

Referred by _____

Medications and dosages:

Reason for taking Medication:

Medical History- Past and Present Medical Problems: Check all that apply

- Diabetes
- High Cholesterol
- Seizures
- HIV/AIDS
- Osteoporosis
- Gastric Reflux
- Migraines/Headaches
- Thyroid Problems Low High
- Anxiety
- Depression
- Other Psychiatric Problems, Type _____
- Kidney Problems, Type _____
- Cancer, Type _____
- Heart Problems/Murmurs, Type _____
- Lung Disease/Tuberculosis, Type _____
- Sexually Transmitted Diseases, Type _____
- Arthritis, Type _____
- Skin Disease, Type _____
- Stomach or Intestinal Problems, Type _____
- Collagen Vascular Disease, Type _____
- Other _____

- Hypertension
- Asthma
- Anemia in last year
- Seasonal Allergies
- Osteopenia
- Stroke
- Deep Vein Thrombosis

Latex Allergy Yes No

Allergies/Bad Reactions to Medications:

Type of reaction:

Gynecologic History:

Last Menstrual Period _____

I have no periods

Periods are every _____ days, lasting for _____ days with light, normal or heavy flow (circle one)

Did you receive the 3 HPV vaccinations between ages 12 and 27? Yes No

Number of Pregnancies _____

Number of Deliveries _____

Number of Miscarriages/Terminations _____

Last Pap Smear _____

Last Mammogram _____

What are you doing to prevent pregnancy? IUD, Type _____ Date: _____ Withdrawal
 Arm Implant Condoms
 Pill, Patch, Ring, Shot Trying to get Pregnant
 Vasectomy, Tubal Not Preventing Pregnancy

Have you ever had any Genetic Testing for cancer risk done? Yes No Type _____

Surgical History: Check all that apply

Appendectomy Freezing of Cervix, Year _____
 Tonsillectomy Leep of Cervix, Year _____
 Gallbladder removal Bladder Surgery, Type _____
 Cesarean Section, how many _____ Breast Surgery, Type _____
 Ectopic Pregnancy Bone or Joint Surgery, Type _____
 Tubal Ligation Cosmetic Surgery, Type _____
 Laparoscopy, for what _____ Gastric Bypass _____
 Hysterectomy, with ovary removal Yes No Other Surgeries: _____
 Other Gynecologic Surgery, Type _____
 Stomach or Bowel Surgery, Type _____

Family History:

Who in your family has the following? Include parents, grandparents, siblings, children, aunts and uncles and whether maternal (mother's) or paternal (father's) side of family.

High Blood Pressure _____

Diabetes _____

Heart Disease _____

Ovarian Cancer _____

Breast Cancer _____

Colon Cancer _____

Social History:

Have you ever smoked? Yes No How many packs per day? _____
When did you quit? _____

Do you drink alcohol? Yes No How many drinks per week? _____

Do you use recreational drugs or medical marijuana? Yes No Type _____

Preventive Medicine:

Last Blood Work for diabetes, cholesterol, thyroid problems _____

Last Colonoscopy _____ Any polyps? Yes No When is your next colonoscopy due? _____

Last Bone Density Test _____