NAME: ______________________ DATE: ___/___/___

REASON FOR VISIT: ☐ ROUTINE PHYSICAL ☐ PROBLEM DESCRIBE PROBLEM: ______________________

CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

MAJOR ILLNESSES	YES	DATE DIAGNOSED		YES	DATE DIAGNOSED
Anemia	☐		Hepatitis	☐	
Anxiety	☐		High Blood Pressure	☐	
Arthritis	☐		Incontinence	☐	
Asthma or other Pulmonary Issues	☐		Kidney Infections	☐	
Bleeding Disorder	☐		Kidney Stones	☐	
Blood Transfusion	☐		Migraine Headaches	☐	
Breast Disease	☐		Osteoporosis	☐	
Cancer	☐		PCOS (Polycystic Ovarian Syndrome)	☐	
Depression	☐		Rheumatic Fever	☐	
Diabetes	☐		Sexually Transmitted Diseases	☐	
Fracture	☐		Stroke	☐	
Frequent Urinary Tract Infections	☐		Tuberculosis (TB)	☐	
Heart Murmur	☐		Thyroid Disease: Hypo / Hyper	☐	
Heart Disease	☐		Ulcers	☐	
OTHER:					

WHEN WAS YOUR LAST TEST OR IMMUNIZATION?

	DATE		DATE
When was your last pap smear?		Have you ever had a colonoscopy? ☐Y ☐N	
Have you ever had an abnormal pap? ☐Y ☐N		Have you had a bone density scan? ☐Y ☐N	
What treatment did you receive?		Have you ever had chickenpox? ☐Y ☐N	
When was your last mammogram?		Have you rec'd HPV/Gardasil immunizations?	
Other:			

PLEASE LIST ANY PAST INJURIES OR ILLNESSES:

TYPE	DATE	TYPE	DATE

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

SURGERY / REASON	DATE	SURGERY / REASON	DATE

NAME:____________________________________

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:		
DRUG NAME	DOSAGE	PHYSICIAN
ALLERGIES TO MEDICATIONS / SUBSTANCES (LATEX GLOVES, ETC.) ?	List:	Reaction:
List all "Natural" or Herbal remedies, over-the-counter drugs, vitamins or minerals you are taking	List:	

CHECK IF YOUR BLOOD RELATIVES HAVE HAD:

MAJOR ILLNESSES ☐ Check here if you were adopted	None	Mother	Father	Brother	Sister	Grandmother (maternal)	Grandmother (paternal)	Grandfather (maternal)	Grandfather (paternal)	Uncle	Aunt
Cancer: Breast, Ovarian or Colon	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Twins	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

YOUR GYN HISTORY

Do you currently use birth control? ☐ Yes	☐ No What type do you currently use?
☐ Condoms	☐ Nuvaring
☐ Depo Provera	☐ Birth Control Patch
☐ Diaphragm	☐ None
☐ IUD (Brand or Type):	☐ Natural Family Plan/Rhythm
– Date Inserted:	☐ Tubal Ligation
☐ Birth Control Pill	☐ Vasectomy
– Name:	☐ Withdrawal
☐ Contraceptive Foam/Jelly	☐ Implanon
☐ Other:	– Date Inserted:

What age did you have your first period:

How many days are there from start of period to start of next period: (days)

How long does your period last? (days) Flow: ☐ Light ☐ Medium ☐ Heavy

Number of Tampons per day: Number of Pads per day:

Date of Last Period:

Do you have blood clots? ☐ Yes ☐ No Do you have spotting or bleeding between periods? ☐ Yes ☐ No

Do you often miss work/school due to your period? ☐ Yes ☐ No

Do you have cramps? ☐ Yes ☐ No Do you have pain? ☐ Yes ☐ No

Have you gone thru Menopause: ☐ Yes ☐ No At what age:

Are you on Hormone Replacement Therapy (hormones)? ☐ Yes ☐ No

NAME: ____________________

YOUR OB HISTORY

	NUMBER		NUMBER
Total # of Pregnancies		Full -Term Births	
Premature Births		Elective Abortions	
Miscarriages		Living children	
Ectopic Pregnancies			

On the chart below, please fill in answers for each pregnancy including abortions; miscarriages, and ectopics.

No.	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight/Sex		Del Type Vag/CSection	Epidural	Early Labor?	Wt Gain	Comments / Complications	Location
1					M F						
2					M F						
3					M F						
4					M F						
5					M F						
6					M F						

SOCIAL HISTORY

PLEASE LIST HABITS

Alcohol ☐ Yes ☐ No
Drinks per day: Drink per week:

Caffeine ☐ Yes ☐ No
Drinks per day: Drink per week:

Drug User ☐ Yes ☐ No
Kind: Frequency:

Smoking ☐ Yes ☐ No
Packs per day: ______ Number of Years: ______
Have you ever been a smoker? ☐ Yes ☐ No

Highest level of education completed:
☐ High school ☐ Some college ☐ Associate's degree ☐ Bachelor's degree ☐ Post graduate degree ☐ Trade school

What is your occupation?

Do you Exercise:
☐ None ☐ Once a week or less ☐ 1-3 times a week ☐ 4 or more times weekly

History of abuse ☐ Yes ☐ No
☐ Physical ☐ Emotional ☐ Sexual

Do you use Seat Belts? ☐ Yes ☐ No

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Engaged ☐ Widowed ☐ Separated ☐ Domestic partners

Are you Sexually Active ☐ Yes ☐ No
Do you have sex with? ☐ Men ☐ Women ☐ Both