**Reason for visit today:**_____

**Primary Care Physician:**_____Phone:_____

**Pharmacy Name:**_____Phone:_____

Address/Location:_____

## Allergies

☐ No Known Drug Allergies

Medication:_____Reaction:_____

Medication:_____Reaction:_____

Medication:_____Reaction:_____

## **Medications** including Herbals and Vitamin

☐ Not taking any prescriptions Medications

Name:_____Strength:_____When Taken:_____When Started:_____

Name:_____Strength:_____When Taken:_____When Started:_____

Name:_____Strength:_____When Taken:_____When Started:_____

Name:_____Strength:_____When Taken:_____When Started:_____

Name:_____Strength:_____When Taken:_____When Started:_____

## Vaccination History

| Have you received... | | | |
|---|---|---|---|
| Gardasil (HPV) | Yes | No | |
| Tetanus/diphtheria/pertussis (whooping cough) (Boostrix) | Yes | No | Year Received:_____ |
| Pneumonia | Yes | No | |
| Hepatitis A | Yes | No | |
| Hepatitis B | Yes | No | |
| Varicella (Chicken Pox) | Yes | No | |

Date of Last Flu Shot:_____

**Family Medical History** especially any history of female cancers (breast, ovarian and/or uterine)

☐ Unknown

Mother:_____

Father:_____

Sisters:_____

Brothers:_____

Maternal Grandmother:_____

Maternal Grandfather:_____

Paternal Grandfather:_____

Paternal Grandmother:_____

Maternal Aunt/Uncle:_____

Paternal Aunt/Uncle:_____

**Social History**

Occupation:_____

Religion: Christian Jehovah's Witness Muslim Hindu Jewish None

Education (highest level completed): HS 9 HS10 HS11 HS12 2 Year College 4 Year College

General Stress Level: Low Medium High

Exercise level: None Occasional Moderate Heavy

Diet: Regular Vegetarian Gluten Free Specific Carbohydrate

Marital Status: Single Married Widowed Divorced

Partner's Name:_____

Age of First Sexual Intercourse:_____

Lifetime Number of Sexual Partners:_____

Currently Sexually Active: Yes No Current Number of Sexual Partners:_____

Sexual Orientation: Heterosexual Homosexual Bisexual

Smoking: None ¼ Pack per Day ½ Pack per Day 1 Pack per Day 1 ½ Pack per Day Quit Years?_____

Alcohol Intake: None Occasional Moderate Heavy Quit

## Past Medical History

| | | | | | |
|---|---|---|---|---|---|
| Abnormal Pap Smear | Yes | No | HIV | Yes | No |
| Accidents/Trauma | Yes | No | HPV/genital warts | Yes | No |
| Anemia/blood disorder | Yes | No | Infertility | Yes | No |
| Anesthetic complication | Yes | No | Involuntary loss of urine | Yes | No |
| Asthma | Yes | No | Kidney disease | Yes | No |
| Birth defects/inherited disease | Yes | No | Migraines | Yes | No |
| Blood transfusion | Yes | No | Osteoporosis | Yes | No |
| Breast Disease | Yes | No | Pelvic infection | Yes | No |
| Cancer | Yes | No | Physical/Metal Abuse | Yes | No |
| Depression/Anxiety | Yes | No | Rh factor | Yes | No |
| DES exposure | Yes | No | Seizures/epilepsy | Yes | No |
| Diabetes | Yes | No | Sexual abuse | Yes | No |
| Endometriosis | Yes | No | Sexually Transmitted Infection | Yes | No |
| Female/Gyn cancer | Yes | No | Stomach/GI problems | Yes | No |
| Heart disease/condition | Yes | No | Thyroid problems | Yes | No |
| Hepatitis | Yes | No | Tuberculosis | Yes | No |
| Herpes | Yes | No | Uterine anomaly | Yes | No |
| High blood pressure | Yes | No | Urinary Tract Infections | Yes | No |
| High cholesterol | Yes | No | Varicosities | Yes | No |

## Surgical History

Name of Procedure:_____Date (dd/mm/yyyy):_____

Name of Procedure:_____Date (dd/mm/yyyy):_____

Name of Procedure:_____Date (dd/mm/yyyy):_____

Drugs: None Cocaine Marijuana Heroin Prescription

Caffeine Intake: None Occasional Moderate Heavy

Is blood transfusion acceptable in an emergency? Yes No

Living Will? Yes No

## GYN History

Last Menstrual Period (dd/mm/yy):_____

Frequency of Cycle: _____days

Flow: Light Moderate Heavy

Duration of Flow _____days

If Post Menopausal, Age at Menopause:_____

Age Menstrual Cycle Began:_____

Current Birth Control:_____

Date of Last Pap:_____

Cramps: Yes No

## Pregnancy History

Total Pregnancies:_____ Full Term Deliveries: _____ Pre Term Deliveries:_____

Miscarriage(s):_____ Elective Abortion(s):_____

| Date (dd/mm/yyyy): | Baby Name: | Sex: | Baby Birth Weight: | Route of Delivery: | Delivering Physician: |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Current Medical Symptoms** Circle all applicable symptoms

| | | | | |
|---|---|---|---|---|
| Fatigue | Fever | Weight gain (___lbs) | Weight loss (___lbs) | |
| Abnormal moles | Rash | Eye irritation | Vision changes | |
| Hearing loss | Ear pain | Nose/sinus problems | Sore throat | Snoring |
| Dry mouth | Mouth ulcer | | | |
| Shortness of breath | Cough | Wheezing | Chest pain | Heart palpitations |
| Heartburn | Nausea | Vomiting | Abdominal pain | Bowel movement changes |
| Diarrhea | Constipation | Rectal bleeding | | |
| Abnormal bleeding | Flank pain | Trouble urinating | Urinary frequency | Urinary urgency |
| Urinary incontinence | Vaginal lesions | Vaginal discharge | Vaginal odor | Vaginal itching |
| Irritability | Tension/anxiety | Depressed mood | Breast pain/tenderness | Bloating |
| Feeling out of control/overwhelmed | Hot flashes | Night sweats | Impaired memory | Decreased libido |
| Painful sex | Muscle Aches | Muscle weakness | Joint pain | Back pain |
| Headaches | Dizziness | Weakness | Numbness | Seizures |
| Depression | Alcoholism | Sleep Disturbance | | |