Name: **Age:** **DOB:** **Date:**

Current Medications: **[ ] None**

Name of Drug	**MG/Dosage**	**Name of Drug**	**MG/Dosage**

Surgery History & Date (Ex: Tonsillectomy, Appendectomy, Hysterectomy, Hernia, Cosmetic Procedures, etc.) **[ ]**

Family History

Father: [ ] Living – Age: [ ] Deceased, Age at Death: Cause:

Mother: [ ] Living – Age: [ ] Deceased, Age at Death: Cause:

Siblings: Number Living: Number Deceased: Cause:

List other illnesses in your family (Ex: Heart Disease, Diabetes, Colon Cancer, Breast Cancer, etc.)

Please list family member and illness (Include if maternal or paterna) **[ ]**

Social History

Do you Smoke? Yes / No If yes, how much? # of packs/day # of years. When did you stop smoking?

Do you Drink? Yes / No If yes, how much?

Have you ever used recreational drugs? (i.e. marijuana, cocaine) If yes, what/when?

Do you exercise regularly? Yes / No If yes, what and how frequently?

Routinely wear seatbelts? Yes / No Routinely wear a helmet? Yes / No Use sunscreen? Yes / No

Marital Status? Occupation? Domestic Violence? Yes / No

Turn Over

Gynecology History

Age at First Period:	Date of Last Pap smear:
Onset of last Menstrual Period:	History of Abnormal Pap: [ ] Yes [ ] No
Are your Cycles Regular: [ ] Yes [ ] No	History of STDs? [ ] Yes [ ] No Please List:
How heavy are your cycles? Light Medium Heavy	Sexually Active: Y / N Partner: Male Female Both
Are your periods painful: [ ] Yes [ ] No	Birth Control Method:
Length of Periods: 3-4 days 5-7 days 7-9 days Other:	

Are you Menopausal / Postmenopausal?	Date of Last Mammogram?
Age at Menopause?	Date of Last Colonoscopy?
Do you use Hormones: [ ] Yes [ ] No	Date of Last Dexa Scan?
How many years total?	Any Gardasil Vaccines? Y / N How Many?

Pregnancy History

Total # of Pregnancies	Miscarriages	Abortions	# of C-Sections	# of Vaginal Deliveries	Total Living Children

Have you had SIGNIFICANT problems with any of the following within the past year?

<u>General</u>

Fever [ ]
Trouble Sleeping [ ]
Weight Gain [ ]
Weight Loss [ ]

<u>Allergic/Immunologic</u>

Hay Fever [ ]
Drug Allergy [ ]
Food [ ]

<u>Eyes</u>

Vision changes [ ]
Double Vision [ ]

<u>Ear/Nose/Throat</u>

Difficulty swallowing [ ]
Sinus Pain [ ]

<u>Endocrine</u>

Fatigue [ ]
Too Cold [ ]
Excessive thirst [ ]
Too hot

<u>Respiratory</u>

Cough [ ]
Short of Breath [ ]
Wheezing [ ]

<u>Breast Problems</u>

Breast Lump [ ]
Breast Pain [ ]
Nipple Discharge [ ]

<u>Cardiovascular</u>

Chest Pain [ ]
Ankle Swelling [ ]
Irreg. heartbeat [ ]

<u>Gastrointestinal</u>

Abdominal Pain [ ]
Blood in stool [ ]
Constipation [ ]
Diarrhea [ ]
Indigestion [ ]
Heartburn [ ]

<u>Hema/Lymphatic</u>

<u>Pre-Menstrual Problems</u>

Bloating [ ]
Swelling [ ]
Mood Changes [ ]
Breast Changes [ ]
Headaches [ ]
Acne [ ]

<u>Menstrual Problems</u>

Cramps/pain [ ]
Heavy bleeding [ ]
Bleeding between periods [ ]
Missed periods [ ]

<u>Menopause Issues</u>

Hot Flashes [ ]
Night Sweats [ ]

<u>Other GYN Issues</u>

Discharge [ ]
Itching/Irritation [ ]
Vulvar Pain [ ]

<u>Sexual Problems</u>

Pain w/ Intercourse [ ]
Bleeding after Intercourse [ ]
Decreased Desire [ ]
Orgasm Issues [ ]
Dryness [ ]
Possible exposure To STD [ ]

<u>Urinary</u>

Incomplete Urination [ ]
Nocturia (getting up at night) [ ]
Frequency > 8 times a day [ ]
Leaking [ ]
Pain [ ]
Bloody urine [ ]

<u>Skin</u>

Rash [ ]
Skin Cancer [ ]

<u>Musculoskeletal</u>

Bone fracture after age 40 [ ]
Bone pain [ ]
Muscle aches [ ]
Joint Pain [ ]
Joint swelling [ ]

<u>Neurological</u>

Dizziness [ ]
Fainting [ ]
Frequent Headaches [ ]
Memory Loss [ ]
Numbness/ Tingling [ ]

<u>Emotional</u>

Depression [ ]
Anxiety [ ]
Serious thoughts about harming yourself [ ]
Harming others [ ]