



Medical History/Information

Date: ___/___/___

Patient Name: _____ Birth Date: ___/___/___ Age: ___ yrs

By what name do you prefer to be called: _____ Primary Care Doctor: _____

Pharmacy Information:

Name: _____ Phone Number: () _____ - _____

Address: _____

Allergies (Please list medications and foods. List what happens when you take the medicine or food):

Immunizations (Enter year)

HPV: _____ Influenza: _____ Tetanus/Diphtheria: _____

Pneumonia: _____ Rubella: _____

Past Medical History (Please check all conditions that apply, medical management, and year of diagnosis)

- | | |
|--------------------------------------|-------------------------------------|
| 1. High Blood Pressure | 13. Intestinal Problems |
| 2. Heart Disease | 14. Arthritis or Back Problems |
| 3. Liver Disease | 15. Urinary Problems |
| 4. Kidney Disease | 16. Osteoporosis |
| 5. Anemia or Blood Clotting Disorder | 17. Gallbladder Problems |
| 6. Blood clots in legs or lungs | 18. Stomach Problems or GERD |
| 7. Neurological Problems | 19. Chronic Fatigue or Fibromyalgia |
| 8. Migraine Headaches | 20. High Cholesterol |
| 9. Depression or Anxiety | 21. Other: _____ |
| 10. Thyroid Problems | |
| 11. Diabetes | |
| 12. Asthma or Lung Problems | |

Enter number from above and explain medical management and year of diagnosis (e.g. # 10, Treated with Synthroid, 1998):

Surgeries (List Procedure and Year)

Hospitalizations (List Problem and Year)

Surgeries (List Procedure and Year)	Hospitalizations (List Problem and Year)



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Gynecologic History (Please check all conditions that apply, medical management, and year of diagnosis)

- | | |
|-----------------------------------|----------------------|
| 1. Abnormal Pap Smear | 11. Uterine Fibroids |
| 2. Abnormal Mammogram | 12. Endometriosis |
| 3. Abnormal periods or bleeding | 13. Sexual Problems |
| 4. Chronic Pelvic Pain | 14. Infertility |
| 5. Polycystic Ovaries (PCOS/PCOD) | 15. Uterine Cancer |
| 6. Sexually Transmitted Diseases | 16. Breast Cancer |
| 7. Genital Warts | 17. Ovarian Cancer |
| 8. Herpes | 18. Other: _____ |
| 9. Pelvic Inflammatory Disease | |
| 10. Recurrent Vaginal Infections | |

Enter number from above and explain medical management and year of diagnosis (e.g. # 6, Chlamydia, Treated with Doxycycline, 2001):

Pregnancy History (List Delivery/Outcome and Year)

Total Number of Pregnancies: _____ Vaginal Deliveries: _____ Number of Miscarriages: _____
 Term (37 wks & Beyond) _____ Cesarean Deliveries: _____ Number of Abortions: _____
 Preterm (prior to 37 wks) _____ Number of Ectopic / Tubal Pregnancies: _____

Current Birth Control Method: _____

Family History

(Please check all conditions that apply and enter the information. Include mother, father, siblings, grandparents, aunts, and uncles. Please include what side of the family, either maternal or paternal.)

Disease	Relationship (Include maternal or paternal)	Age of Onset	Age of Death
<input type="checkbox"/> High Blood Pressure			
<input type="checkbox"/> Heart Disease			
<input type="checkbox"/> Stroke			
<input type="checkbox"/> Thyroid Problems			
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> Mental Health Problems			
<input type="checkbox"/> Ovarian Cancer			
<input type="checkbox"/> Breast Cancer			
<input type="checkbox"/> Colon Cancer			
<input type="checkbox"/> Osteoporosis			
<input type="checkbox"/> Other:			



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Social History (Please check all that apply)

Smoking History: Never smoked

Quit; how long ago? _____ How many years did you smoke? _____ How many packs/day? _____

Currently smoke; How many years have you smoked? _____ How many packs/day? _____ Type of Tobacco? _____

Alcohol: drinks/week _____ Exercise: times/week _____ Caffeine: drinks/day _____ Type of caffeine: _____

Are you experiencing any abuse in your life? No Verbal Physical

How do you manage the stress in your life? Well Average Poor

Eating Habits: Mostly Healthy Should eat less Should eat more Eat irregularly throughout the day Mostly Unhealthy Foods

How do you spend most of your time? Homemaker / Mother Student Job/Profession: _____

Health Maintenance (Enter date of last time you had the screening test)

Pap smear: ___/___/___ Mammogram: ___/___/___ DEXA (Bone scan): ___/___/___

Colonoscopy: ___/___/___ PCP Physical: ___/___/___ Cholesterol/Lipid Panel: ___/___/___

Medications (List Prescription, Over-the-Counter, Supplements, and Herbal medications)

Table with 3 columns: Drug/Supplement/Herbal, Dose, How Often? (7 rows)

Provider Comments

Signature of Patient: _____

Signature of Provider: _____