



Patient History

Name _____ Preferred Nickname _____ D.O.B. _____ Age _____

Marital Status: Single In a Relationship Married Widowed Divorced

Sexual Orientation: Heterosexual Homosexual Bisexual Transgender

Spouse/Partners Name: _____

Family Physician or Primary Care Provider: _____

Your Employment/Occupation: _____

Preferred Pharmacy: _____

Medication Allergies: _____

List ALL Current Medication (including over the counter):

Past Medical History:

Do you have, or have you ever had: (Please Check all that apply)

| | | | |
|---------------------------------|-----------------------------|-------------------------------------|------------------------------------|
| Acid Reflux/Gerd | Chronic Kidney Disease | High Cholesterol | Osteoporosis |
| Asthma/ Emphysema/ Lung Disease | Crohn's /Ulcerative Colitis | HIV | Pancreatitis |
| Anemia | Depression | Hypertension | Pelvic Inflammatory Disease |
| Anxiety | Diabetes | HPV/ Genital Warts | Seasonal Allergies |
| Arthritis | Endometriosis | Irritable Bowel Syndrome | Seizure Disorder |
| Autoimmune Disorder- | Fibroids | Leukemia/Lymphoma | Stroke |
| Bleeding or Clotting Disorders | Gonorrhea | Liver Disease | Syphilis |
| Blood Transfusion | Heart Attack | Migraines | Thyroid Disorder |
| Bowel Obstruction | Heart Disease | Mitral Valve Prolapse | Urinary Incontinence |
| Cancer- What Kind? | Hepatitis, Type: | Multiple Endocrine Neoplasia Type 2 | Uterine Prolapse |
| Chlamydia | Herpes, Type: | Osteopenia | Varicella or Vaccine (Chicken Pox) |

Other: _____

Date of Last Well Women's Health Exam: _____ Last Pap Smear: _____

Do you have a history of an abnormal pap: No Yes, If history of abnormal pap:

- When? _____
- Type of Abnormality: _____
- Was there any treatment? LEEP Laser Cone Biopsy

Do you perform Self Breast Exams? Y / N If so, how often? _____

| HAVE YOU HAD A: | Date of Last: |
|---|---|
| Mammogram | |
| Bone Density | |
| Colonoscopy | |
| HPV/ Gardasil Vaccine | Is Series Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cholesterol Check Results? <input type="checkbox"/> Normal <input type="checkbox"/> High | |

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Social History:

Tobacco Use: Never Current, How much? _____ Former, Quit at Age _____

Alcohol Use: Never Yes, average number of drinks per week _____

Recreational Drug Use: No Yes, What and How often _____

History of Sexual Abuse/Assault: No Yes History of Physical Abuse/Assault: No Yes

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Reproductive History:

First day of last menstrual period: ____/____/____ If Menopausal, age of Menopause: _____

Method of Contraception: None Pill Vasectomy Condoms Rhythm Method Vaginal Ring
 Depo Provera IUD Nexplanon Tubal Ligation

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Obstetrical History: (please list all that apply and how many of each)

Pregnancies: _____ Miscarriages: _____ Elective Abortions: _____
 Fetal Demise: _____ Ectopic: _____ Multiples (Twins): _____ Living Children

| Birthdate | Weeks | Baby's Weight | Sex | Type of Delivery | Anesthesia | Complications | Location | Baby's Name |
|-----------|-------|---------------|-----|------------------|------------|---------------|----------|-------------|
| | | | | | | | | |
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Past Surgical History:

Have you ever had surgery? Y / N If yes, please list surgery date & type

| Year | Description | Year | Description |
|------|-------------|------|-------------|
| | | | |
| | | | |
| | | | |

Have you had other hospitalizations? Y / N If yes, please list date & type of procedure

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Family History:

Do you have a family history of any of the following? Please list the affected family member(s):

| Condition: | Relation to you: | Condition: | Relation to you: |
|---------------------|------------------|------------------------|------------------|
| Asthma | | Melanoma | |
| Breast Cancer | Age: _____ | Mental Health Disorder | |
| Colon Cancer | Age: _____ | Osteoporosis | |
| Diabetes | | Ovarian Cancer | Age: _____ |
| Heart Disease | | Pancreatic Cancer | Age: _____ |
| High Blood Pressure | | Stroke | |
| High Cholesterol | | Thyroid Disorder | Age: _____ |

Any other medical problems in the family? Please list _____