NAME DATE OF BIRTH TODAY'S DATE

PRIMARY DR

HAVE YOU EVER HAD:	Yes	No
High blood pressure		
Heart Problems		
Obesity		
Lung Problems		
Diabetes		
Thyroid Disease		
Cancer		
Radiation or Chemo		
Anemia		
Blood Transfusion		
Blood Clot		

	Yes	No
Migraine Headaches		
Hospitalization		
Depression		
Addiction		
Kidney Problems		
Incontinence		
Liver Problems		
Stomach Problems		
Anxiety		
Other		
Other		

About your Periods:
1st Date of Last Period ____
Age at First Period ____
Age at Menopause ____
Hormone replacement ? ____

About your Paps:
Last Pap ____
Abnormals ____
Procedures colpo cryo cone
HPV vaccine ? ____

About your Contraception:
Using now ____
Used in the past ____
Vasectomy yes no

Check if you have ever had:
Chlamydia ____ PID ____
Cold sores ____ Herpes ____
Genital warts ____ Other ____

About your pregnancies:
total pregnancies ____
full term babies ____
pre-term (before 36 wks) ____
abortions ____
miscarriages ____

vaginal deliveries ____
c-sections ____
Complications ____
breastfed ____

Past surgeries:

Past surgeries (cont)

Are you…………………….. Single Married Divorced Widowed

Do you use……………….. Tobacco Alcohol Marijuana

Has anyone in your immediate family had:
Breast Cancer ____
Other Cancer ____
Diabetes ____
High Blood Pressure ____
Heart Disease ____
Blood Clot ____

When was your last:
Blood work ____
Mammogram ____
DEXA scan ____
Colonoscopy ____

Medication Allergies:

For Doctor:

FM/107HH