

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

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 Abnormals _____
 Procedures colpo cryo cone
 Gardasil HPV vaccine _____

Type of pregnancy prevention (ie: pills, IUD, Vasectomy, Tubal)

Currently 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 _____

Year of your last:

Blood work			
Mammogram			
DEXA scan			
Colonoscopy			

Medication Allergies:

For Doctor:

