NAME DATE OF BIRTH TODAY'S DATE

PRIMARY DR OCCUPATION

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		
Anxiety		
Depression		
Addiction		
Kidney Problems		
Incontinence		
Stomach Problems		
Other		

ABOUT YOUR PERIODS

1st Date of Last Period _____
Age at First Period _____
Age at Menopause _____
Hormone Replacement? _____

ABOUT YOUR PAPS

Last Pap _____
Abnormals _____
Gardasil HPV Vaccine _____
Procedures _____
Colpo Cryo Cone

TYPE OF PREGNANCY PREVENTION

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 Other_____
Do you use..... Tobacco Alcohol Marijuana Other_____

HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD

Breast Cancer _____
Other Cancer _____
Diabetes _____
High Blood Pressure _____
Heart Disease _____
Blood Clot _____

YEAR OF LAST

	YEAR	YEAR	YEAR
Blood Work			
Mammogram			
DEXA Scan			
Colonoscopy			

MEDICATION ALLERGIES _____

_____
_____

OFFICE USE ONLY

FM/107HH *REVISED: 8/24*