



NAME: _____ AGE _____

Date of Birth: _____

What are the reasons for your visit today?

Do you have any of the following health problems now or in the past?

<p>Yes</p> <p><input type="checkbox"/> Abuse (physical/emotional)</p> <p><input type="checkbox"/> Anxiety or depression</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Blood Clots</p> <p><input type="checkbox"/> Blood in Urine</p> <p><input type="checkbox"/> Bloody/dark stools</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Convulsions</p> <p><input type="checkbox"/> Diabetes</p>	<p>Explain</p>	<p>Yes</p> <p><input type="checkbox"/> Frequent Urination</p> <p><input type="checkbox"/> Gall bladder disease</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Hearing/vision problems</p> <p><input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Kidney disease</p> <p><input type="checkbox"/> Sexual concerns</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Thyroid disease</p> <p><input type="checkbox"/> Ulcers/indigestion</p>	<p>Explain</p>
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Health Risk Factors:

Do you?:	Yes	No	
Do self breast exam?	<input type="checkbox"/>	<input type="checkbox"/>	
Any changes?	<input type="checkbox"/>	<input type="checkbox"/>	
Exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>	
Type _____ Freq _____			
Smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Cigs/day _____
Consume Alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Drinks/wk _____
Use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
Use sunscreen regularly?	<input type="checkbox"/>	<input type="checkbox"/>	
Wear seat belts?	<input type="checkbox"/>	<input type="checkbox"/>	
Eat dairy products daily?	<input type="checkbox"/>	<input type="checkbox"/>	Servings/day _____
Eat fruits & vegetables daily?	<input type="checkbox"/>	<input type="checkbox"/>	
Follow a low-fat diet?	<input type="checkbox"/>	<input type="checkbox"/>	
Take calcium supplements?	<input type="checkbox"/>	<input type="checkbox"/>	
Take vitamin supplements?	<input type="checkbox"/>	<input type="checkbox"/>	

Menstrual History:

Age at first period _____ First day of last period ____ / ____ / ____

Cycle length: ____ days Flow ____ days heavy mod light

Has anyone in your family had the following:

	Who?
Heart attack	_____
Diabetes	_____
High blood pressure	_____
Osteoporosis	_____
Colon cancer	_____
Breast cancer	_____
Uterine cancer	_____
Ovarian cancer	_____
Birth defects	_____
Other: _____	_____

Do you have any Medication or Latex Allergies?

<u>Medication</u>	<u>Reaction</u>
_____	_____
_____	_____
_____	_____

Please list your current medications, dose, and how often you take them (include herbs, vitamins, and supplements):

<u>Medication</u>	<u>Dose</u>	<u>Frequency Taken</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had any of the following gyn history?

	Explain
<input type="checkbox"/> Herpes	
<input type="checkbox"/> Gonorrhea/Chlamydia	
<input type="checkbox"/> Genital Warts	
<input type="checkbox"/> Abnormal pap smear	
<input type="checkbox"/> IUD in the past	
<input type="checkbox"/> Current birth control method _____	
Date of last pap smear ____ / ____ / ____	
Date of last mammogram ____ / ____ / ____	

Have you ever had prior Surgery?

<u>Year</u>	<u>Procedure</u>
_____	_____
_____	_____
_____	_____

Have you ever had any prior pregnancies?

<u>Year</u>	<u>Type birth</u>	<u>Wt.</u>	<u>Complications</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____