Print Form

PLEASE COMPLETE THESE FORMS AND BRING THEM WITH YOU TO YOUR VISIT

NAME: _____ **SSN:** _____

PAST MEDICAL HISTORY

- ☐ High Blood Pressure
- ☐ Thyroid disorder
- ☐ Heart attack/angina
- ☐ Cancer
- ☐ Mitral Valve prolapse/other heart problems
- ☐ Osteoporosis
- ☐ Lung Problems/asthma
- ☐ Kidney problems
- ☐ Blood clots/phlebitis
- ☐ Diabetes
- ☐ GI/stomach problems
- ☐ Psychiatric Disorder/ Depression
- ☐ Stroke

Provide details of above/describe other medical problems

YEAR	LIST ALL SURGERIES/OPERATIONS

MEDICATIONS YOU ARE CURRENTLY TAKING

(include prescription,herbals,vitamins, over-the-counter)

NAME	DOSE	#/DAY

LIST ALL ALLERGIES

DRUG	REACTION

Comments from physician to above

Family History Do any members of your family have any of the following

- ☐ Heart disease
- ☐ Diabetes
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Blood Clots
- ☐ Other diseases

Relative	Comments by physician to above

Reviewed/MD Signature _____

Date _____

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NAME: _____ **SSN:** _____

Date of last PAP: _____ ◯ Normal ◯ Abnormal

Date of last mammogram _____ ◯ Normal ◯ Abnormal

Did you have or have you had in the past:

YES	NO		DESCRIBE
☐	☐	Abnormal PAPs	
☐	☐	Treatment of abnormal Pap/dysplasia etc.	
☐	☐	Painful menstrual cramps	
☐	☐	Heavy menstrual flow	
☐	☐	Current birth control method	
☐	☐	Sexually Transmitted Diseases	
☐	☐	Current sexual partner	

Comments from physician to above

_____

_____

PREGNANCY HISTORY

YEAR	OUTCOME

YOUR MENSTRUAL PERIODS

First day of last period _____

Are they regular ☐ **YES** ☐ **NO**

How often do you get them _____ **Days**

Age of first period _____

Age of Menopause _____

URINARY,MENOPAUSE,SEXUALITY

Do you have:

YES	NO	
☐	☐	Urine leak with cough, sneeze
☐	☐	Urine leak without cough, sneeze
☐	☐	Painful urination
☐	☐	Night time urination
☐	☐	Frequent urination
☐	☐	Vaginal discharge
☐	☐	Hot flashes
☐	☐	Dry Skin
☐	☐	Decreased sex drive
☐	☐	Decreased orgasm, lubrication

Number of partners in lifetime _____

Comments by physician to above

_____

_____

Reviewed/MD Signature _____ **Date** _____

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NAME: _____ **SSN:** _____

Diet and Exercise

 # daily servings of dairy products: _____ **Veggies/Fruit:** _____

List type of exercise and how often per week: _____

IMMUNIZATION: Mark date you last received the following (mark "unknown" if you don't remember)

Tetanus vaccine/booster: _____ Varicella (Chicken Pox) _____ HPV _____

Influenza (Flu vaccine): _____ Pneumovax: _____

Rubella (German Measles) _____ Hepatitis B: _____

SOCIAL HISTORY ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Cohabitating/Partner

Occupation: _____

Do you Smoke YES ☐ **NO** ☐ **Packs per day and number of years** _____

Do you Drink YES ☐ **NO** ☐ **Number of drinks per day,** _____

Do you use Drugs YES ☐ **NO** ☐ **If Yes** ☐ Cocaine ☐ Marijuana ☐ Heroin ☐ LSD ☐ Other

General	Eyes	Ears,Nose,Throat	Heart	Respiratory	Gastrointestinal
☐ Fatigue	☐ Blurred Vision	☐ Trouble hearing	☐ Chest Pain	☐ Cough	☐ Nausea/Vomitting
☐ Recent wt loss	☐ double vision	☐ Sore Throat	☐ Irreg heart beat	☐ Short/Breath	☐ Heartburn ☐ Stomach pain
☐ Recent wt gain	☐ See Spots	☐ Sinus Problems	☐ Palpitations	☐ Wheezing	☐ Blood/Black Stools
			☐ Swollen ankles	☐ Congestion	☐ Constipation/Diarrhea

Urination	Muscular	Skin/Breasts	Nervous System	Heme/Lymph	Allergy/Immune
☐ Painful	☐ Aches	☐ Rash	☐ Heat Ache	☐ Bruise easily	☐ Seasonal allergies
☐ Bloody	☐ Joint Pain	☐ Lump/Discharge	☐ Numbness	☐ Bleed excessively	☐ Latex allergy
☐ Too Often		☐ Painful Breasts	☐ Dizziness	☐ Swollen glands	☐ Iodine allergy

Comments by Physician: ☐ **None of the above** ☐ **All other systems reviewed and negative**

_____

_____

_____

_____

_____

Reviewed/MD Signature _____

Date _____