Please fill in all information on front and back of form **PLEASE USE BLACK INK ONLY**

Today's Date_____

Name_____ Date of Birth ____/____/_____

Referred by _____ Primary Care Doctor _____

Reason for today's visit _____ Pharmacy Address & Phone #_____

Menstrual History

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

Your periods occur every _____days and last for _____days

Any problems with your periods? ☐ No ☐ Yes

☐ Heavy flow ☐ Clots ☐ Pain/Cramping ☐ Irregular periods ☐ Discharge

☐ Bleeding between periods ☐ Other_____

If menopausal

Age/year began_____ Any Postmenopausal bleeding? ☐ No ☐ Yes

Did you/are you taking hormones? Yes No

Gynecological History

Have you had any of the following? (Check all that apply)

☐ Abnormal Pap Smear ☐ Breast Pain ☐ Chronic Pelvic Pain

☐ DES Exposure ☐ Endometriosis ☐ Genital Warts

☐ Infertility ☐ Ovarian Cysts ☐ Pain with Intercourse

☐ PID ☐ PMS ☐ Recurrent Miscarriage

☐ Recurrent Vaginitis ☐ STD _____

☐ Urinary Incontinence ☐ UTI (chronic) ☐ Uterine Fibroids

☐ **None of the above** *(additional medical history on the back of form)*

Contraceptive History

Are you currently sexually active? ☐ Yes ☐ No ☐ Never been

How many life time partners? _____ How many in the last year?_____

Current method of birth control (Include tubal or vasectomy) _____

Any problems with current method? ☐ No ☐ Yes _____

Previously used methods (Check all that apply)

☐ Birth Control Pill ☐ Condoms ☐ Diaphragm ☐ Depo Provera ☐ IUD

☐ NuvaRing ☐ Implanon ☐ Nexplanon ☐ Spermicide ☐ Sponge ☐ Other

☐ No previous birth control

Preventive Care History

Last WWE: _____

Last Pap Smear Date:_____ ☐ Normal ☐ Abnormal

Last Mammogram Date: _____ ☐ Normal ☐ Abnormal

Last Colonoscopy Date:_____ ☐ Normal ☐ Abnormal

Last DEXA (Bone Scan) Date: _____ ☐ Normal ☐ Abnormal

Last Cologuard Date: _____ ☐ Normal ☐ Abnormal

Vaccinations (year) Gardasil _____ Flu _____

Hepatitis B _____ TDAP (Tetanus) _____

Total Pregnancies	Full Term Deliveries	Premature Deliveries	Elective Terminations	Miscarriages	Ectopics	Multiples	Living

Date MM/DD/YYYY	Gestation Age #Wks@Delivery	Hours in Labor	Birth Weight	Sex	Type of Delivery	Type of Anesthesia	Early Labor	Comments/Complications Gestational Diabetes	Hospital

Your age at first delivery:

Surgical History (Please list all surgical procedures) ☐ None

Surgery_____ Date_____

Surgery_____ Date_____

Surgery_____ Date_____

Surgery_____ Date_____

Surgery_____ Date_____

Allergy History (List all medication allergies and reaction) ☐ None

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Current Medication History

(Please include current prescriptions and medications ONLY) ☐ None

Drug name_____ Dose_____

Drug name_____ Dose_____

Drug name_____ Dose_____

Drug name_____ Dose_____

Drug name_____ Dose_____

Drug name_____ Dose_____

Social & Lifestyle History

Marital Status _____ Occupation_____

Tobacco Smoker ☐ Never ☐ Former ☐ Current - Amt/Day_____

Alcohol Use ☐ No ☐ Yes If yes, Amt/Wk_____

Caffeine Use ☐ No ☐ Yes Street Drugs/Marijuana use ☐ No ☐ Yes

Domestic Abuse ☐ No ☐ Yes If yes, ☐ Current or ☐ Past

Regular Exercise ☐ No ☐ Yes Type_____ Amt/Wk_____

Monthly Breast Exam ☐ No ☐ Yes Have you had Chicken Pox ☐ No ☐ Yes

Do you have a Health Care Directive (living will) ☐ No ☐ Yes

Past Medical History

Indicate Relationship

Anemia	☐ Self	☐ Family ->
Anxiety	☐ Self	☐ Family ->
Asthma	☐ Self	☐ Family ->
Blood Clotting Disorder	☐ Self	☐ Family ->
Cancer; Breast	☐ Self	☐ Family ->
Cancer; Cervical	☐ Self	☐ Family ->
Cancer; Colon	☐ Self	☐ Family ->
Cancer; Ovarian	☐ Self	☐ Family ->
Cancer; Skin-type:_____	☐ Self	☐ Family ->
Cancer; Uterine	☐ Self	☐ Family ->
Cancer; Other ->	☐ Self	☐ Family ->
Cardiac Arrhythmia	☐ Self	☐ Family ->
Coronary Artery Disease	☐ Self	☐ Family ->
Crohn's Disease	☐ Self	☐ Family ->
Cystic Fibrosis	☐ Self	☐ Family ->
Deep Vein Thrombosis (DVT)	☐ Self	☐ Family ->
Depression	☐ Self	☐ Family ->
Diabetes-type:_____	☐ Self	☐ Family ->
Eating Disorder-type:_____	☐ Self	☐ Family ->
Gastric Ulcer	☐ Self	☐ Family ->
Gastroesophageal Reflux Disease	☐ Self	☐ Family ->
Gestational Diabetes	☐ Self	☐ Family ->
Hepatitis-type:_____	☐ Self	☐ Family ->
Hyperlipidemia (High Cholesterol)	☐ Self	☐ Family ->
Hypertension (High Blood Pressure)	☐ Self	☐ Family ->
Irritable Bowel Syndrome	☐ Self	☐ Family ->
Kidney Stones	☐ Self	☐ Family ->
Lupus	☐ Self	☐ Family ->
Migraines	☐ Self	☐ Family ->
Multiple Sclerosis	☐ Self	☐ Family ->
Osteoporosis	☐ Self	☐ Family ->
Parkinson's Disease	☐ Self	☐ Family ->
Pulmonary Embolism	☐ Self	☐ Family ->
Rheumatoid Arthritis	☐ Self	☐ Family ->
Scoliosis	☐ Self	☐ Family ->
Seizures	☐ Self	☐ Family ->
Sickle - Cell Disease	☐ Self	☐ Family ->
Sleep Apnea/Disorder	☐ Self	☐ Family ->
Stroke	☐ Self	☐ Family ->
Thyroid Disorder-type:_____	☐ Self	☐ Family ->
Tuberculosis	☐ Self	☐ Family ->
Ulcerative Colitis	☐ Self	☐ Family ->

Other Medical History we should know about ->

Are there any other problems that are important to you today?

☐ No ☐ Yes _____

_____

_____

Patient Signature:_____

Experiencing Today / Recently

Review of Systems - You are currently having any of the following:

Constitutional	Fever	☐ Yes	☐ No
	Chills	☐ Yes	☐ No
	Sweats	☐ Yes	☐ No
	Weight loss	☐ Yes	☐ No
	Weight gain	☐ Yes	☐ No
	Fatigue	☐ Yes	☐ No
Eyes	Impaired Vision	☐ Yes	☐ No
Head, Ears, Nose, & Throat	Headaches	☐ Yes	☐ No
	Sinus Congestion	☐ Yes	☐ No
Breast	Lumps	☐ Yes	☐ No
	Tenderness	☐ Yes	☐ No
	Swelling	☐ Yes	☐ No
	Nipple Discharge	☐ Yes	☐ No
Cardiovascular	Chest pain	☐ Yes	☐ No
	Loss of Consciousness	☐ Yes	☐ No
Respiratory	Shortness of breath	☐ Yes	☐ No
	Wheezing	☐ Yes	☐ No
	Cough	☐ Yes	☐ No
Gastrointestinal	Nausea	☐ Yes	☐ No
	Vomiting	☐ Yes	☐ No
	Diarrhea	☐ Yes	☐ No
	Constipation	☐ Yes	☐ No
	Blood in stools	☐ Yes	☐ No
Genitourinary	Urinary urgency	☐ Yes	☐ No
	Urinary frequency	☐ Yes	☐ No
	Urinary Incontinence	☐ Yes	☐ No
	Blood in urine	☐ Yes	☐ No
Integument (Skin)	Rash	☐ Yes	☐ No
	Change in moles, lesions	☐ Yes	☐ No
	Change in hair growth/loss	☐ Yes	☐ No
Neurologic	Muscular weakness	☐ Yes	☐ No
	Incoordination	☐ Yes	☐ No
	Tingling or numbness	☐ Yes	☐ No
Musculoskeletal	Joint pain	☐ Yes	☐ No
	Muscle pain	☐ Yes	☐ No
Endocrine	Excessive thirst	☐ Yes	☐ No
	Excessive urination	☐ Yes	☐ No
	Temperature intolerance	☐ Yes	☐ No
Psychiatric	Anxiety	☐ Yes	☐ No
	Depression	☐ Yes	☐ No
	Feeling Confused	☐ Yes	☐ No
	Difficulty Sleeping	☐ Yes	☐ No
	Excessive Anger	☐ Yes	☐ No
Heme-Lymph	Easy bleeding	☐ Yes	☐ No
	Easy bruising	☐ Yes	☐ No
	Swollen lymph glands	☐ Yes	☐ No
Allergic-Immunologic	Sinus allergy symptoms	☐ Yes	☐ No
	Frequent illnesses	☐ Yes	☐ No

Height:

Weight:

BP:

Reviewed by:_____