

Name _____ Date _____

Date of Birth _____ Age _____ Primary Care Physician _____ Pharmacy _____

Married ___ Single ___ Divorced ___ Partnered ___ *Partner M or F* Employer _____ Job Title _____

ALLERGIES: (include reaction i.e. rash, breathing problems)

MEDICATIONS AND DOSAGES: Include vitamins, minerals and herbals supplements.

HEALTH MAINTENANCE: Have you ever had any of the tests/vaccines listed below? When and what was the result?

	<i>Month/ Year</i>	<i>Results</i>	<i>Treatments</i>
Pap test			
Any abnormal paps			
Mammogram			
Colonoscopy			
DEXA (bone density test)			
Cholesterol test			
Adult screening labs			
Tetanus-diphtheria booster			
Shingles Vaccine			

SURGERIES: Include dates

MAJOR ACCIDENTS OR INJURIES/HOSPITALIZATIONS – include dates

___ When was the first day of your **last menstrual period?**

___ How many times have you been pregnant?

___ Number of living children

___ Number of Vaginal Deliveries ___ C-sections

___ Number of Abortions

___ Number of Miscarriages

___ How old were you when you started your periods?

___ How often are your periods?

___ How long do you bleed?

___ Flow of period ___ Light ___ Moderate ___ Heavy

___ Are you having problems with your periods?

___ If yes, explain _____

___ Are you sexually active?

___ What method of birth control are you using?

___ Are you having any **sexual concerns?**

___ Are you worried about **exposure to STDs?**

___ Have you ever had an STD? Type _____ When _____

___ Are you having problems with **pelvic pain?**

___ Are you having frequent or **painful urination?**

___ Do you have any abnormal **vaginal discharge?**

___ Do you have any abnormal **vaginal itching?**

___ Are you having problems with **urine leakage?**

___ Do you smoke?

Current Smoker-Everyday (indicate how much) _____

Current Smoker-occasional _____ Former Smoker

Never Smoked Smoker-current status unknown Unknown if ever smoked

___ Do you use alcohol or drugs? _____

How often? _____

WHAT ARE YOUR CONCERNS? _____

Name _____ Date of Birth _____

Please check and date the squares below for you and close family members who had any of these diagnoses.

Diagnosis	Self	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alzheimer's									
Alcoholism									
Asthma									
Bladder problems									
Blood Clotting Disorders									
Blood Clots in Legs (DVT)									
Cancer									
Breast									
Cervical									
Colon									
Ovarian									
Uterine									
Other									
Depression									
Developmental delay									
Diabetes									
Endometriosis									
Fibroids									
Gallbladder prob.									
Headache, chronic									
Heart Disease									
Hepatitis/ jaundice									
High Blood Pressure									
High Cholesterol									
HIV / AIDS									
Inherited Disease									
Kidney Disease									
Liver disease									
Lung Disease									
Mental Illness									
Migraines (with or without Aura)									
Obesity									
PCOS									
Seizure Disorder									
Sickle Cell									
Stroke									
Thyroid Disease									

If they pertain to you, please list date and treatment for condition below. Explain above marked diagnoses and any additional problems.
