MEDICAL HISTORY

Name: _____ DOB: _____

Reason for visit: _____

List of ALL medications INCLUDING DOSAGE and over the counter:

_____

_____

_____

HISTORY OF ALL MEDICAL CONDITIONS DIAGNOSED WITH:

_____

History of any psychological conditions: _____

Date of last: Annual Physical _____ Bone Density _____

Colonoscopy _____ Glucose _____ Cholesterol _____

Dental exam_____ Eye exam _____

Immunizations/Vaccines: Tetanus _____ Flu _____ Pneumonia _____ Shingles _____

Hepatitis A _____ Hepatitis B _____ HPV(Gardasil) _____ Meningitis _____

ALLERGIES TO MEDICATIONS_____

First day of last period: _____ Age at first period: _____

How is your menstrual flow: Light_____ Moderate_____ Heavy_____ How many days_____

Cramps with cycle: Yes, _____ No_____ Do you have PMS: Yes, _____ No _____

Bleeding between cycles: Yes, ____ No ____ Bleeding with intercourse: Yes, _____ No_____

Birth control name: _____

History of STD: Yes, _____ No _____

Date of last pap smear: _____ Results: _____

History of abnormal pap: Yes, _____ When: _____ Result: _____ No_____

Mammogram _____Problems with breast: Yes, _____ No_____

Hysterectomy: _____ When: _____

Problems with urination Yes, _____ No _____

Vaginal discharge: Yes, _____ No _____

Number of Pregnancies _____ C-section _____

Surgeries: _____

Hospitalizations: _____

Family History: Breast cancer_____ Uterine cancer_____ Ovarian cancer_____

Colon cancer _____ Diabetes_____ Heart disease ____ High blood pressure_____

Stroke ____ Thyroid disease _____ Autoimmune _____ Osteoporosis_____

Other family history _____

Smoker: Yes, _____ No _____ Past smoker when did you stop _____

Alcohol: Yes, _____ How often: _____ No _____ Social drugs: Yes, _____ No _____

Do you have an advanced directive: Yes, _____ No _____