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PATIENT HISTORY

Patient name: D.O.B.: Age:

Marital Status: Ethnicity:

Home Address:

City: State: Zip Code:

Home Phone: Cell Phone:

Social Security:

Pharmacy Name: Phone:

Address:

Reason for Visit: Please list all symptoms/concerns:

1.
2.
3.

Medical History:

Age when menses started:

Date of Last menstrua period:

Are your Cycles Regular: *Y* *N* Complete Cycle Days: *< 21* *21-32* *33-45* *Other*

Number of days Cycle lasts:

Flow: *Heavy* *Moderate* *Light* Pain/Cramps: *Y* *N*

Date of your last pap smear: Have you ever had an abnormal pap smear? *Y* *N*

If yes, please explain:

Do you have any symptoms now related to menopause? *Y* *N*

If yes, please explain:

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Are you currently using a method of birth control: Y N

If yes, please provide details: _____

Have you ever had any of the following diseases (please check all that apply and add dates?

Gonorrhea	Date:	Bacterial Vaginosis	Date:
Chlamydia	Date:	Trichomoniasis	Date:
Syphilis	Date:	Genital Warts	Date:
Herpes	Date:		

Total Number of Pregnancies (including miscarriages and abortions): _____

Please list all details of pregnancies:

Date of Delivery | Vaginal or C-Section | Weeks at delivery | Any additional information

- _____
- _____
- _____
- _____
- _____

Please check all that apply that pertain to YOUR personal health history: ·

High Blood Pressure	Heart Trouble	Kidney Stones
High Cholesterol	Heart Attack	Liver Disease
Blood clots	Varicose Veins	Goiter/Thyroid Disease
Diabetes	Cancer	Anemia
Asthmacolitis	Stomach Ulcer	Epilepsy
Substance Abuse	Gall Bladder Disease	Mental Illness
Chickenpox	Rheumatic Fever	German Measles
Hepatitis	Any other diseases	_____

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Surgical History. Please check all that apply.

Cesarean Section Date: _____ Hernia Repair Date: _____

Removal of Ovaries Date: _____ Hysterectomy Date: _____

Appendectomy Date: _____ Thyroidectomy Date: _____

Gall Bladder Date: _____ Hemorrhoidectomy Date: _____

Tubal Ligation Date: _____ D&C Date: _____

Any other operations Date: _____

Type and Frequency of exercise: _____

What type and how many alcoholic drinks per week: _____

Tobacco Use: ☐ Yes ☐ No

If yes, how many packs per day: _____

And how many years have you smoked: _____

Recreational Drug Use: ☐ Yes ☐ No

If yes, list the type and frequency of use: _____

Medications and Vitamins, you are currently taking: _____

Family History please, please provide information applicable to you:

Diabetes Who: _____ Ovarian Cancer Who: _____

Uterine Cancer Who: _____ Hypertension Who: _____

Thyroid Who: _____ Mental Disorder Who: _____

Addiction Who: _____ Hereditary Disease Who: _____

Breast Cancer Who: _____ Colon Cancer Who: _____

Heart Disease Who: _____ TB/Hepatitis Who: _____

Anemia Who: _____ Alcoholism Who: _____

Mental Retardation: _____ Birth Defects Who: _____