Patient Name: _____

Date of Birth: _____

Name of Referring Physician/Provider: _____

PAST HISTORY

Medical Problems/ Illnesses

_____ _____

_____ _____

_____ _____

Have you ever had a blood transfusion? No Yes If yes, when?_____

Medications - Current none

_____ _____

_____ _____

_____ _____

Allergies & Reactions none

_____ _____

_____ _____

Surgeries (procedure/date/place):

_____ _____

_____ _____

VACCINE: **Gardasil (HPV):** No Yes **Varicella:** No Yes
Influenza: No Yes Other: _____

FAMILY HISTORY

Mother: Living Deceased - Cause_____ Father: Living Deceased - Cause_____
Sibling: Number Living____ Number Deceased_____ Cause(s) _____
Diabetes_____ Heart Disease_____ High cholesterol_____
Stroke_____ High blood pressure_____ Cancer_____
Other_____

SOCIAL HISTORY

- Have you ever smoked cigarettes? No Yes
  - Do you currently smoke cigarettes? No Yes
  - How many packs per week? _____
- Do you drink alcohol? No Yes
- How many drinks per week? _____

Have you ever used illicit drugs or drugs not prescribed for you? No Yes

- Have you ever experienced domestic violence? No Yes
- Do you regularly use a seat belt? No Yes
- Do you get regular exercise? No Yes
- Marital Status: M S W D Sep
- School Completed: High School College Graduate Degree Other

PAST OBSTETRICAL/GYNECOLOGIC HISTORY

Period: Age at onset: _____ Length (days): _____ Type ( ) Heavy, ( ) Light, ( ) Cramps, ( ) Clots

First Day of Last Menstrual Period: _____ Age of menopause: _____

History of sexually transmitted diseases: none yes_____

Contraception: none yes (type) _____

Abnormal pap smear: no yes (treatment) _____

How many pregnancies? _____ How many resulted in live births? _____

Miscarriages none yes (number) _____ Abortions none yes (number) _____

Deliveries:	Date	Vaginal/Cesarean	Forceps/Vacuum	Sex of child	Weight
1					
2					
3					
4					

REVIEW OF SYSTEMS (check all that apply):

Gastrointestinal ☐ **no problems**
- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ nausea or vomiting
- ☐ rectal bleeding or blood in stools
- ☐ other _____

Cardiovascular ☐ **no problems**
- ☐ chest pain
- ☐ history of angina or heart attack
- ☐ high blood pressure
- ☐ history of irregular beat
- ☐ history of poor circulation
- ☐ other _____

Pulmonary/lungs ☐ **no problems**
- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing
- ☐ other _____

Muscle/joint/bone ☐ **no problems**
- ☐ swollen joints
- ☐ joint pain/stiffness
- ☐ muscle cramps/spasm
- ☐ back pain
- ☐ other _____

Neurologic ☐ **no problems**
- ☐ history of stroke
- ☐ blackouts or loss of consciousness
- ☐ memory loss
- ☐ numbness/tingling
- ☐ other _____

Hematologic/Lymphatic ☐ **no problems**
- ☐ easy bruising
- ☐ swollen glands
- ☐ other _____

General ☐ **no problems**
- ☐ weight gain/loss
- ☐ poor sleep
- ☐ fever
- ☐ headache
- ☐ other _____

Eyes, ears, nose, throat ☐ **no problems**
- ☐ blurred vision
- ☐ history of glaucoma
- ☐ loss of hearing
- ☐ ringing in ears
- ☐ sinus problems
- ☐ hoarseness
- ☐ other _____

Genitourinary ☐ **no problems**
- ☐ frequent urination
- ☐ urinary retention
- ☐ blood in urine
- ☐ urinary leakage
- ☐ stool leakage
- ☐ abnormal periods
- ☐ painful intercourse
- ☐ other _____

Skin ☐ **no problems**
- ☐ itching
- ☐ easy bruising
- ☐ change in moles
- ☐ other _____

Endocrine ☐ **no problems**
- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst
- ☐ other _____

Psychiatric ☐ **no problems**
- ☐ depression
- ☐ anxiety
- ☐ other _____

Signature of Reviewing Provider: _____ **Date**: _____