PATIENT HISTORY FORM

Name ______________________

Date of Birth ______________________

Date ______________________

Age: ________ Marital Status: ______________ Occupation: ______________ Primary Care Provider: ______________

Reason for your visit today: ______________________________

Current Contraception: ❑ None ❑ Tubal Ligation ❑ IUD ❑ Mirena® ❑ Nuva Ring® ❑ Patch ❑ Natural Family Planning ❑ Depo Provera ❑ Condoms ❑ Diaphragm ❑ Vasectomy ❑ Pills - Brand: ______________________________

If Postmenopausal, are you on Hormone Replacement Therapy? ❑ Yes ❑ No Have you ever been on HRT? ❑ Yes ❑ No

Medication Allergies: ❑ None ❑ ______________________________

List all prescription medications you are currently using: ❑ None ❑ ______________________________

List all non-prescription medications or supplements you are currently using: ❑ None ❑ ______________________________

What was the first day of your last menstrual period? ______________

When was your last mammogram? ______________

Do you perform breast self-exams monthly? .... ❑ Yes ❑ No

When was your last PAP test? ______________

Do you have a history of Sexually Transmitted Disease? .... ❑ Yes ❑ No

Have you had 5 or more sexual partners? .... ❑ Yes ❑ No

Was your age at first intercourse under 16? .... ❑ Yes ❑ No

Were you exposed to DES before your birth? .... ❑ Yes ❑ No

Have you ever had an abnormal PAP smear?............................... ❑ Yes ❑ No

Do you exercise regularly? .... ❑ Yes ❑ No

Do you use seat belts? .... ❑ Yes ❑ No

Do you smoke? .... ❑ Yes ❑ No

How much? ______________

Do you drink alcohol? .... ❑ Yes ❑ No

How much & how often? ______________

Do you use any recreational drugs? .... ❑ Yes ❑ No

What & how often? ______________

Surgeries or Hospitalizations: ❑ None

Type of surgery or reason for hospitalization	Date	Doctor	Hospital or Facility

Pregnancies (include losses and terminations)

Year	Male/Female	Weight	Vaginal or Section	Complications

Do you have or have you ever had…

Diabetes ❑ Yes ❑ No
Asthma ❑ Yes ❑ No
Stroke ❑ Yes ❑ No
Ulcers ❑ Yes ❑ No
Heart disease ❑ Yes ❑ No
Chronic anemia ❑ Yes ❑ No
Thyroid disorder ❑ Yes ❑ No

High blood pressure ❑ Yes ❑ No
Mitral valve prolapse ❑ Yes ❑ No
Seizures/Epilepsy ❑ Yes ❑ No
Tuberculosis ❑ Yes ❑ No
Bowel trouble ❑ Yes ❑ No
Kidney stones ❑ Yes ❑ No
Bleeding disorder ❑ Yes ❑ No

Chronic lung condition ❑ Yes ❑ No
Alcohol abuse ❑ Yes ❑ No
Drug/substance abuse ❑ Yes ❑ No
Hepatitis/liver disorder/Jaundice ❑ Yes ❑ No
Blood clots in legs/lung/heart ❑ Yes ❑ No
Autoimmune diseases (lupus, etc.) ❑ Yes ❑ No
Depression, anxiety ❑ Yes ❑ No

Osteoporosis ❑ Yes ❑ No
High cholesterol ❑ Yes ❑ No
Rheumatic fever ❑ Yes ❑ No
Blood transfusion ❑ Yes ❑ No
Transfusion reactions ❑ Yes ❑ No
Anesthetic reactions ❑ Yes ❑ No
Eating disorder ❑ Yes ❑ No

Cancer ❑ Yes ❑ No If yes, Type, Date and Treatment: ______________________________

Other disease? ______________________________

Please list any major illnesses that have occurred in your family. Is there a family history of…

Breast Cancer ❑ Yes ❑ No
Ovarian Cancer ❑ Yes ❑ No
Colon Cancer ❑ Yes ❑ No

Thyroid disorder ❑ Yes ❑ No
Coronary artery disease ❑ Yes ❑ No
High cholesterol ❑ Yes ❑ No

Osteoporosis ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No
Other: ______________________________

Stroke ❑ Yes ❑ No
High blood pressure ❑ Yes ❑ No