

PATIENT INFORMATION

For office use only	Abstracted (Y / N)
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Date: _____

Full Name (First, Middle, Last): _____ DOB: _____

Nickname: _____ Preferred language _____ Occupation _____

How did you hear about us? _____ Age: _____

Primary Care Physician: _____ Phone _____

Pharmacy name and location: _____

Phone: _____ Fax: _____

I am being seen today for: _____

Do you want to be tested for STD? YES NO

Be aware that insurance companies do not allow you to be seen for *pap/annual/wellness care on the same day* that you have a specific complaint/problem that needs to be addressed.

Medication: Please list all current medications

None _____

Medication	Dose

Drug Allergies:

None _____

Drug	Reaction

Herbal Supplements _____

Vitamins YES NO

Calcium YES NO

Medical History:

Condition/Treatment	Date

Surgical History (including cosmetic):

Procedure	Date

Review of Systems

Any complaints with: (Y/N)

Heart	Yes	No	Vaginal Area	Yes	No
Lungs	Yes	No	Skin Problems	Yes	No
Breasts	Yes	No	Weight	Yes	No
Bowels	Yes	No	Vision	Yes	No
Kidneys/Bladder	Yes	No	Hearing	Yes	No

Do you have bladder concerns (leaking, pain, etc) **Yes** **No**

GYN History

Menstrual cycle:

Age periods began _____ or age that you stopped having periods _____

Last menstrual period _____

Are they: Regular _____ Irregular _____ # of days you bleed _____

Pain with periods? Absent Mild Moderate Severe Just kill me

Medication used for menstrual pain? _____ How many days? _____

Sexual History:

Are you currently sexually active? YES NO Ever active? YES NO

Current birth control method: _____

Past birth control methods: _____

Have you ever been a victim of sexual assault/abuse? YES NO When? _____

Have you had a sexually transmitted disease in the past 5 years? YES NO Type _____

Health Maintenance History

	Never	Date of Last	Abnormal Results/ Date & Treatment
PAP Smear			
Mammogram			
Dexa Scan (Bone Density)			
Cholesterol			
Colonoscopy			

Obstetrical History

Miscarriages _____

Abortions _____

Year	Vaginal/ C-Section	Weeks	Sex	Weight	Obstetrical/ Neonatal Problems	Delivery Doctor

Social History

Marital Status: single married separated widowed partnered Name: _____

Currently smoke? YES NO

Drink alcohol? YES NO Amount _____ Frequency _____

If sober when did you achieve? _____

Vaccines: Please indicate the date of your last vaccine

Tetanus (Td) _____

Pertusis (Whooping cough) _____

HPV/Cervarix/Gardasil _____

Seasonal Influenza _____

Pneumonia (pneumovax) _____

Varicella _____

Shingles/Zoster _____

Hepatitis A _____

Hepatitis B _____

TB skin Test _____

Family History: No family History available _____ I am adopted _____

Condition	Yes or No	Which Relative
Heart Problems		
High Blood Pressure		
Diabetes		
Breast Cancer		
Ovarian Cancer		
Other Cancer		
Other Conditions		