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**Name:** _____ **Name you prefer to be called:** _____

**Referred by**: _____ **Primary Care Doctor/Provider**: _____

**Please select the reason for your visit today**:

- ☐ Abnormal Radiologic Finding
- ☐ Abnormal Pap Smear
- ☐ Annual Well Woman Exam
- ☐ Bleeding Problems
- ☐ Breast Symptoms
- ☐ Contraception Issues
- ☐ Menopause/Perimenopause Issue
- ☐ Menstrual Symptoms
- ☐ Pain: Abdominal/Pelvic
- ☐ Prolapse
- ☐ Urinary/Incontinence or Symptoms
- ☐ Vaginal/Vulvar Symptoms

Other/Please explain: _____

**Gynecologic History:**

Last menstrual period date: _____
Age of first period: _____
Age of Menopause: _____
Period Every _____ days. Regular ☐ Irregular ☐
Heavy Periods? ☐ Cramps? ☐ PMS/Moodiness? ☐
Night Sweats? ☐ Hot Flashes? ☐ Decreased Libido? ☐
Sexually Active? Yes ☐ No ☐ Not Currently ☐ Never ☐
Intercourse a problem? No ☐ Yes ☐
Birth Control Method: On Contraception ☐ None ☐ N/A ☐
Hysterectomy? Yes ☐ No ☐

**Obstetrical History:**

Total pregnancies: _____
Full-term deliveries: _____
Preterm deliveries: _____ Weeks: _____
Miscarriages: _____ Abortions: _____
Ectopic/Tubal Pregnancies: _____
Twin Pregnancies: _____
Living Children: _____
Largest: _____lb _____oz
Vaginal Deliveries: _____ C-Sections:_____
Complications: _____ None

Last PAP Smear Year: _____ --------> Have you ever had an abnormal PAP smear? Yes ☐ No ☐
Last Mammogram Year: _____ ---------> Have you ever had Breast Cancer? Yes ☐ No ☐
DEXA Bone Density Scan Year: _____ ---------> Do you have a history of? Osteopenia ☐ Osteoporosis ☐
Screening Colonoscopy Year: _____ ---------> Results: Normal ☐ Abnormal ☐ Family Hx Colon Cancer? Yes ☐ No ☐
Gardasil Vaccine? Yes ☐ No ☐ Have you ever had a sexually transmitted infection? Yes ☐ No ☐

**Past Medical History** (Have you ever had?)

- ☐ Anxiety
- ☐ Asthma/Chronic Bronchitis/COPD
- ☐ Atrial Fibrillation
- ☐ Blood clotting disorder/Blood Thinner
- ☐ Blood Transfusion
- ☐ Breast Cancer
- ☐ Chronic Kidney Disease
- ☐ Colon Cancer
- ☐ Congestive Heart Failure
- ☐ COVID Infection/COVID Vaccination
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis/Diverticulitis
- ☐ DVT/PE
- ☐ GERD/Reflux
- ☐ Glaucoma
- ☐ Heart Attack/Angina
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Stones
- ☐ Malignant Hyperthermia (Family Hx)
- ☐ Migraines
- ☐ MRSA Skin Infection
- ☐ Oxygen/Home Oxygen
- ☐ Panic Attacks
- ☐ Post-Operative Nausea/Vomiting
- ☐ Problems with Anesthesia
- ☐ PTSD
- ☐ Sleep Apnea/CPAP
- ☐ Stents/Heart Valve
- ☐ Stroke/TIA

Other: _____

**Surgical History:** Please list all surgeries and biopsies that you have undergone:

| Procedure | Year | Procedure | Year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***** **PLEASE COMPLETE BOTH SIDES OF THIS FORM** *****

**Name:** _____

**Medications and Allergies:** including vitamins, herbal, and over the counter medications:

| Medication and Dose | Medication and Dose | MEDICATION ALLERGY |
|---|---|---|
| 1. | 7. | 1. |
| 2. | 8. | 2. |
| 3. | 9. | 3. |
| 4. | 10. | 4. |
| 5. | 11. | 5. |
| 6. | 12. | **No Known Drug Allergies** ☐ |
| **Pharmacy Name & Location:** | | |

**Family History:** Please select if you have a family history of the following

| Condition | What Family Member/Relation | Age of Diagnosis | Age of Death |
|---|---|---|---|
| Breast/Ovarian/Uterine/Cervical Cancer | | | |
| Colon Cancer | | | |
| Other Cancer Type _____ | | | |
| Blood Clotting Disorder | | | |
| Malignant Hyperthermia | | | |
| High Blood Pressure | | | |
| Elevated Cholesterol | | | |
| Coronary Artery Disease | | | |
| Diabetes | | | |
| CVA/Stroke | | | |
| Thyroid Disorders | | | |
| Other: | | | |

**Social History:**

**Are you**: Single☐ Engaged☐ Married☐ Separated☐ Widowed☐ Divorced☐ Long-Term Relationship☐Same-Sex Relationship ☐

**What is your occupation**? _____ **If retired, previous occupation**? _____

**What do you do for exercise/fun**? _____ **How would you describe your diet**? _____

**Do you smoke cigarettes/vape**? Never☐ _____pk/s per day **Quit Smoking** _____ (year) **Have you ever tried to quit**? Yes ☐No ☐

**Do you drink alcohol**? Never☐ Rare☐ Occasional☐ _____drink/s per wk **Use any illicit drugs**? Yes ☐No ☐

**Have you ever been abused**? No ☐ Yes: Physically☐ Sexually☐ Emotionally☐ Verbally☐ **Safe now**? Yes☐ No☐

**Review of Systems:**

Please select any other symptoms you may be having:

☐**General:** Weight gain, Weight loss, Fatigue, Loss of height

☐**Eyes:** Vision changes, Blurring, Corrective lenses

☐**Ears, Nose, Mouth, Throat:** Drainage, Discharge, Hoarseness, Hearing Problems, Vertigo

☐**Cardiovascular:** Chest Pain, Leg pain with walking, Shortness of breath with exertion, Leg swelling

☐**Respiratory:** Wheezing, Cough, Sputum production, Home O2

☐**Gastrointestinal:** Nausea, Vomiting, Constipation, Diarrhea, Blood in stools, Change in stools, Pain with BM

☐**Musculoskeletal:** Back pain, Arthritis, Weakness

☐**Skin and/or Breast:** Rash, Change in moles, Breast lumps, Breast pain, Nipple Discharge

☐**Neurologic:** Numbness, Dizziness, Headaches, Difficulty walking, Fainting spells, Tremors

☐**Psych:** Anxiety, Depression, Difficulty sleeping

☐**Endocrine:** Hot/cold intolerance, Excessive thirst

☐**Hematologic/Lymphatic:** Easy bruising, Swollen glands, Anemia, Blood clotting disorder, Healing problems

☐**Allergy:** Seasonal, Iodine, Latex; Steroid Use

**Other Symptoms:** _____