

Date: \_\_\_\_\_ Patient's Name: \_\_\_\_\_

Primary Care  
Provider's Name: \_\_\_\_\_

Primary Care  
Provider's Phone #: \_\_\_\_\_

**ALLERGIES:**

Are you allergic to any medication:  Yes  No

Name of medication

Reaction: *(rash, itching, shortness of breath, nausea, etc.)*

_____	_____
_____	_____
_____	_____

**MEDICATIONS:** *(List any medications you are presently taking, including vitamins/supplements)*

_____	_____	_____
_____	_____	_____
_____	_____	_____

**PERSONAL SURGICAL HISTORY:** *(Check any surgical procedures you have undergone and list the date performed)*

- |   |   |
|---|---|
| <input type="checkbox"/> Appendectomy _____                     | <input type="checkbox"/> Heart Surgery (type) _____           |
| <input type="checkbox"/> Breast Biopsy Left/Right _____         | <input type="checkbox"/> Hysterectomy Vaginal/Abdominal _____ |
| <input type="checkbox"/> Breast Reduction _____                 | <input type="checkbox"/> LEEP/Conization _____                |
| <input type="checkbox"/> Breast Augmentation (implants) _____   | <input type="checkbox"/> Removal of Ovaries _____             |
| <input type="checkbox"/> Colonoscopy _____                      | <input type="checkbox"/> Sterilization _____                  |
| <input type="checkbox"/> C-Section ____ (indicate number) _____ | <input type="checkbox"/> Tonsillectomy _____                  |
| <input type="checkbox"/> D & C _____                            | <input type="checkbox"/> Other _____                          |
| <input type="checkbox"/> Endometrial Ablation _____             | <input type="checkbox"/> Hysterectomy _____                   |
| <input type="checkbox"/> Gall Bladder _____                     | Reason for Hysterectomy _____                                 |

**PERSONAL MEDICAL HISTORY:** *(check any medical problems that you currently have or have had in the past)*

**Cancer (indicate type)**

- Breast
- Cervical
- Colon
- Endometrial
- Lung
- Ovarian
- Other \_\_\_\_\_

**Cardiac (heart)**

- High Blood Pressure
- High Cholesterol
- Heart Attack
- Mitral Valve Prolapse

**Endocrinology**

- Diabetes Mellitus (during pregnancy)
- Diabetes Mellitus (non-insulin dependent)
- Diabetes (insulin dependent)
- Thyroid Problems
  - Hypothyroidism
  - Hyperthyroidism
- Osteoporosis
- Osteopenia

**Gastrointestinal**

- Crohn's Disease
- Ulcerative Colitis
- Gallbladder Disease
- GERD (Reflux)
- Irritable Bowel Syndrome (IBS)
- Liver Disease
- Hepatitis

**Hematology**

- Anemia
- Blood Clotting Disorder
- Blood Transfusion
- DVT (Deep Vein Thrombosis)
- PE (Pulmonary Embolism/Clot in Lung)
- Sickle Cell Disease/Trait

**Infectious Disease**

- Chicken Pox
- Shingles
- HIV
- Tuberculosis/Positive PPD

**Neurology**

- Alzheimer's/Dementia
- Headache/Migraines
- Numbness in Hands/Feet
- Seizures/Epilepsy
- Stroke

**Psychiatric**

- ADD/ADHD
- Anxiety
- Bipolar Disease
- Depression
- Eating Disorder
- Panic Attacks

**Pulmonary**

- Asthma
- COPD/Emphysema
- Seasonal Allergies

**Rheumatology**

- Arthritis
- Autoimmune Disease
- Fibromyalgia

**Urology**

- Frequent Urinary Tract Infections
- Hematuria (blood in urine)
- Kidney Disease
- Kidney Infection
- Incontinence (bladder leakage)

**SOCIAL HISTORY:**Do you smoke cigarettes?  Yes  No How much per day: \_\_\_\_\_Have you used tobacco products in the past?  Yes  No If yes, when did you stop smoking: \_\_\_\_\_Do you use e-cigarettes or vape?  Yes  No Explain: \_\_\_\_\_Does anyone else in your household smoke cigarettes?  Yes  No Explain: \_\_\_\_\_Alcohol use:  Yes  No How much per day/week: \_\_\_\_\_Drug use:  Yes  No Describe: \_\_\_\_\_Caffeine:  None  Occasional  Moderate  HeavyExercise:  Light  Moderate  Heavy

Occupation: \_\_\_\_\_ Education Level Completed: \_\_\_\_\_

Relationship Status:  Married  Single  Divorced  Widowed Religious Affiliation: \_\_\_\_\_Is a blood transfusion acceptable in an emergency?  Yes  No

What is your gender identity? \_\_\_\_\_ What is your sexual orientation? \_\_\_\_\_

**GYN HISTORY:**Date of most recent  
Pap Smear: \_\_\_\_\_Date of most recent  
Mammogram: \_\_\_\_\_Date of most recent  
Bone Density: \_\_\_\_\_Location of most recent  
Pap Smear: \_\_\_\_\_Location of most recent  
Mammogram: \_\_\_\_\_Location of most recent  
Bone Density: \_\_\_\_\_History of: *(Please check all items that apply)* Abnormal Pap Smear

Describe: \_\_\_\_\_

 Ovarian Problems PCOS Chlamydia Gonorrhea HPV/Genital Warts Infertility Trichomonas Endometriosis Bacterial Vaginosis Herpes Simplex Fibroids Yeast Infections SyphilisAre you sexually active?  Yes  No

Current birth control method: \_\_\_\_\_

**MENSTRUAL HISTORY:**

Age started menstrual cycle: \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

# of days of bleeding with your period: \_\_\_\_\_

# of days from start of one period to the start of the next period: \_\_\_\_\_

Flow is:  mild  moderate  heavyMenstrual Cramps:  None  Mild  Moderate  SevereBleed between Periods:  Yes  No**FAMILY MEDICAL HISTORY:** *(Please indicate relationship: mother, father, sister, brother, grandmother, etc.)* Cancer (breast/ovarian/uterine/colon/pancreas/other) \_\_\_\_\_ Depression \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Stomach Ulcer \_\_\_\_\_ Diabetes \_\_\_\_\_ High Cholesterol \_\_\_\_\_ Stroke \_\_\_\_\_ Endometriosis \_\_\_\_\_ Irritable Bowel \_\_\_\_\_ Hypothyroidism \_\_\_\_\_ Fibroids \_\_\_\_\_ Osteopenia \_\_\_\_\_ Hyperthyroidism \_\_\_\_\_ Heart Attack \_\_\_\_\_ Osteoporosis \_\_\_\_\_ Ulcerative Colitis \_\_\_\_\_**IMMUNIZATIONS:** *(Please provide the year the immunization was given)* Hepatitis B \_\_\_\_\_ Varicella (Chicken Pox) \_\_\_\_\_ Flu shot \_\_\_\_\_ Tetanus (DT) \_\_\_\_\_ COVID-19 Vaccine \_\_\_\_\_ Gardasil/HPV \_\_\_\_\_**PREGNANCY HISTORY:**

How many times have you been pregnant: \_\_\_\_\_

How many deliveries have you had: \_\_\_\_\_

# of living children: \_\_\_\_\_

# of miscarriages: \_\_\_\_\_

# of abortions: \_\_\_\_\_

# of Ectopic Pregnancies: \_\_\_\_\_