I. PATIENT INDENIFICATION (PLEASE PRINT) (PLEASE USE BLACK INK)

Today's Date: _____ / _____ / _____

Patient's Name: _____ DOB: _____/_____/_____

Address: _____

Phone #: (_____)_____ Work # (_____)_____ Cell # (_____)_____

Email: _____

Local Pharmacy Name: _____Pharmacy Phone Number: (_____) _____

Pharmacy City & State:_____Mail Order Pharmacy:_____

II. REASON FOR SEEING DOCTOR/PROVIDER: _____

_____

_____

III. MEDICAL HISTORY: (CHECK THE APPROPRIATE BOX)

HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD, PLEASE SPECIFY MATERNAL OR PATERNAL:

		You	Your Family	Explain checked answers
1.	**Anemia…….……**	□	□	_____
2.	**Anxiety……..**	□	□	_____
3.	**Arthritis…….**	□	□	_____
4.	**Asthma……...……...**	□	□	_____
5.	**Autoimmune Disease……**	□	□	_____
6.	**Bladder Problems..……...**	□	□	_____
7.	**Bleeding Problems/Disorder……**	□	□	_____
8.	**Breast Problems……...**	□	□	_____
9.	**Cancer…….……..**	□	□	_____
10.	**Chlamydia…….**	□	□	_____
11.	**Congenital Malformation……**	□	□	_____
12.	**Congestive Heart Failure……**	□	□	_____
13.	**COPD ……**	□	□	_____
14.	**Coronary Artery Disease……..**	□	□	_____
15.	**CVA/Stroke……..……..**	□	□	_____
16.	**Depression …….**	□	□	_____
17.	**Diabetes Mellitus……..…….**	□	□	_____
18.	**Drug or Alcohol Dependency.....….**	□	□	_____
19.	**Gastrointestinal Disease……**	□	□	_____
20.	**Gonorrhea……..**	□	□	_____
21.	**Hepatitis.…….**	□	□	_____
22.	**Herpes Simplex Virus……..……..**	□	□	_____
23.	**HIV……..**	□	□	_____
24.	**Hyperlipidemia (High Cholesterol)..**	□	□	_____
25.	**Hypertension (High Blood Pressure)**	□	□	_____
26.	**Infectious Disease……**	□	□	_____
27.	**Infertility…….....**	□	□	_____
28.	**Kidney Disease……...**	□	□	_____
29.	**Migraine Headaches……..**	□	□	_____
30.	**Neurological Disease……..**	□	□	_____
31.	**Osteopenia/Osteoporosis……**	□	□	_____
32.	**Psychological Trauma……**	□	□	_____
33.	**Pulmonary Disease…….**	□	□	_____
34.	**Seizure Disorder…….**	□	□	_____

35. **Thrombophlebitis/Blood Clots…….** □ □ _____
36. **Thyroid Problem……** □ □ _____
37. **Transfusion……..** □ □ _____
38. **Tuberculosis (TB)……..** □ □ _____
39. **Urinary Tract Problems……** □ □ _____
40. **OTHER……** _____

IV. Please answer the following questions putting an (**X**) in the box next to the word YES or NO, except where you are asked for specific information.

MENSTRUATION:

If you have not begun to menstruate, please go to question 8.

1. **How old were you when you first began menstruating?** _____ **years old**
2. **What was the first day of your last menstrual period?** _____ **month** _____**day** _____**year**
3. **Are you past your menopause?** _____**YES** _____**NO**

If YES, skip to question 8

4. **Was your last menstrual period normal?** _____**YES** _____**NO**
5. **How many days pass between the first day of each period?** _____ **days pass**
6. **How long did your period last?** _____ **days**
7. **Are your periods usually painful?** _____ **YES** _____ **NO**

GYNECOLOGY:

8. **Do you examine your breast at least once a month?** _____ **YES** _____ **NO**
9. **Have you ever had a Mammogram?** _____ **YES** _____ **NO**

If YES, what was the month & year of your last test? _____**Month** _____ **year of last mammogram**

Have you ever had an abnormal Mammogram _____ **YES** _____ **NO**

10. **Have you ever had a Pap test?** _____ **YES** _____ **NO**

If YES, write in the month and year of last test? _____**month** _____**year of last Pap test**

11. **Have you ever had abnormal results from a Pap test?** _____ **YES** _____ **NO**
12. **Are you currently having sexual intercourse?** _____ **YES** _____ **NO**
13. **Current number of sexual partners** _____

_____

14. **Sexual Orientation** _____
15. **Do you use birth control on a regular basis?** _____ **YES** _____ **NO**
16. **What forms of birth control have you or your partner used?**

_____

For patients over 50 years of age

1. Have you ever had a bone density/DEXA scan? _____ **YES** _____ **NO** **When?**_____**Results**_____

2. Have you ever had a colonoscopy? _____ **YES** _____ **NO** **When?**_____**Results**_____

MEDICATIONS NOW TAKING:

17. **Are you taking any medication?**

Name: _____ **Reason:**_____ **Dose:** _____ **Frequency:** _____
Name: _____ **Reason:**_____ **Dose:** _____ **Frequency:** _____
Name: _____ **Reason:**_____ **Dose:** _____ **Frequency:** _____
Name: _____ **Reason:**_____ **Dose:** _____ **Frequency:** _____
Name: _____ **Reason:**_____ **Dose:** _____ **Frequency:** _____
Name: _____ **Reason:**_____ **Dose:** _____ **Frequency:** _____

18. **Any Vitamins or Supplements?**

Name: _____ **Dose:** _____ **Frequency:** _____
Name: _____ **Dose:** _____ **Frequency:** _____
Name: _____ **Dose:** _____ **Frequency:** _____

19. Are you allergic to or do you react poorly to any medication? **_____ YES _____ NO**

Medication Name	Reaction

V. SURGERY Please list those operations or serious illnesses that you have had which required hospitalization. If you have had more then six (6), check this box. □ **DO NOT INDICATE PREGNANCIES IN THIS SECTION**

Month/Year	Illness or Operation	Attending Physician's Name	Complications NO	YES
/			□	□
/			□	□
/			□	□
/			□	□
/			□	□
/			□	□

V. PREGNANCY HISTORY (COMPLETE ALL INFORMATION)

# of Pregnancies	# of Premature Births	# of Miscarriages	# of Spontaneous Abortions	# of Induced Abortions	# of Living Children

# Of Term Births	Born Month/ Year	Baby's Sex	Weight at Birth	Weeks Pregnant (Term=40 wks)	Hours in Labor	Type of Delivery	Type of Anesthesia	Complications NO	YES
1	/		lbs. oz.					□	□
2	/		lbs. oz.					□	□
3	/		lbs. oz.					□	□
4	/		lbs. oz.					□	□
5	/		lbs. oz.					□	□
6	/		lbs. oz.					□	□
7	/		lbs. oz.					□	□

SOCIAL HISTORY **YES** **NO** **HOW MUCH**

20. Drug Use ____ ____ _____

21. Alcohol Use ____ ____ _____

22. Caffeine Use ____ ____ _____

23. **Tobacco: ____ Current Smoker ____ Former Smoker ____ Never a Smoker**

24. **Exercise: Type_____ Frequency_____ Type:_____**

25. **Language: _____**

26. **Ethnicity: ____ Hispanic or Latino ____ Not Hispanic or Latino ____ Prefers not to report**

27. **Race: ____ American Indian or Alaska Native ____ Asian ____ Black or African American ____ More than one race**

____ Native Hawaiian ____ Other Pacific Islander ____ White ____ Prefers not to report

28. **Nutrition: Well Balanced Diet_____Poorly balanced diet_____**

Vegetarian_____Special Diet_____

YES **NO**

29. Have you ever been a victim of domestic violence or sexual abuse? ____ ____