

**I. PATIENT IDENTIFICATION (PLEASE PRINT) (PLEASE USE BLACK INK)**

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone Number: (\_\_\_\_) \_\_\_\_\_

**II. REASON FOR SEEING DOCTOR:** \_\_\_\_\_

**III. MEDICAL HISTORY: (CHECK THE APPROPRIATE BOX)**

**HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD:**

	You	Your Family	Explain checked answers
1. Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Autoimmune Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Bladder Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Breast Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Chlamydia.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Congenital Malfunction.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Congestive Heart Failure.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. COPD .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Coronary Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. CVA.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Depression .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Diabetes Mellitus.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Drug Dependency.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Emotional Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Endocrine disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
18. Gastrointestinal Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
19. Gonorrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
20. Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
21. Herpes Simplex Virus.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
22. HIV.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
23. Hyperlipidemia.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
24. Hypertension .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
25. Infectious Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
26. Infertility.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
27. Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
28. Migraine Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
29. Neurological Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
30. Psychological Trauma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
31. Pulmonary Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
32. Seizure Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
33. Thrombophlebitis.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
34. Transfusion.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
35. Tuberculosis (TB).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
36. Urinary Tract Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
37. OTHER.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

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.

**MENSTRATION:**

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
- 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. Do you use birth control on a regular basis? \_\_\_\_\_ YES \_\_\_\_\_ NO
- 14. What forms of birth control have you or your partner used? \_\_\_\_\_

**MEDICATIONS NOW TAKING:**

15. 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: \_\_\_\_\_

16. Any Vitamins or Supplements?

- Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_
- Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_
- Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

17. 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 than six (6), check this box.  **DO NOT PUT PREGANCIES HERE.**

Month/Year	Illness or Operation	Attending Physician's Name	Complications	
			NO	YES
/			<input type="checkbox"/>	<input type="checkbox"/>
/			<input type="checkbox"/>	<input type="checkbox"/>
/			<input type="checkbox"/>	<input type="checkbox"/>
/			<input type="checkbox"/>	<input type="checkbox"/>
/			<input type="checkbox"/>	<input type="checkbox"/>
/			<input type="checkbox"/>	<input type="checkbox"/>

**V. PREGNANCY HISTORY (COMPLETE ALL INFORMATION)**

# Of Pregnancies _____	# of Premature Births _____	# of Miscarriages _____	# of Spontaneous Abortions _____	# of Induced Abortions _____	# of Living Children _____
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# 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	
			lbs.	oz.					NO	YES
1	/		lbs.	oz.					<input type="checkbox"/>	<input type="checkbox"/>
2	/		lbs.	oz.					<input type="checkbox"/>	<input type="checkbox"/>
3	/		lbs.	oz.					<input type="checkbox"/>	<input type="checkbox"/>
4	/		lbs.	oz.					<input type="checkbox"/>	<input type="checkbox"/>
5	/		lbs.	oz.					<input type="checkbox"/>	<input type="checkbox"/>
6	/		lbs.	oz.					<input type="checkbox"/>	<input type="checkbox"/>
7	/		lbs.	oz.					<input type="checkbox"/>	<input type="checkbox"/>

**SOCIAL HISTORY**

**YES NO HOW MUCH**

- 18. Drug Use \_\_\_\_\_
- 19. Alcohol Use \_\_\_\_\_
- 20. Tobacco Use \_\_\_\_\_
- 21. Caffeine Use \_\_\_\_\_

22. Exercise Yes: \_\_\_\_\_ No: \_\_\_\_\_

23. Language \_\_\_\_\_

24. Ethnicity: \_\_\_\_\_ Hispanic or Latino \_\_\_\_\_ Not Hispanic or Latino \_\_\_\_\_ Prefers not to report

25. 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