

PATIENT NAME _____ DOB: _____ SS# _____ AGE: _____

Past Medical History: (circle) Glaucoma Cataracts Thyroid Diabetes Kidney Stone Polycystic Kidney Disease Renal Disease/Failure Hypertension Heart Attack Coronary Artery Disease Congestive Heart Failure Arrhythmia Phlebitis/DVT Stroke Embolus (blood clot) Bleeding Disorder Clotting Disorder Anemia Asthma Emphysema COPD TB Arthritis Fibromyalgia Osteopenia Osteoporosis Irritable Bowel Syndrome (IBS) Gallbladder Ulcers Liver Disease/Cirrhosis Ulcerative Colitis/Crohn's Hepatitis Seizures/Epilepsy Migraines Alzheimers Alcoholism Drug Addition Anxiety Depression Panic Disorder BiPolar Other, Specify _____

Cancer, Type & Date Diagnosed _____

Menstrual History: Date Last Period Began: _____ # of days between periods: _____ Duration: _____

Age at first period _____ Do you have a period every month: YES or NO Current method of Birth Control _____

Is your period normally : Light Medium Heavy Clots Cramps: YES or NO History of Abnormal PAP Smear: YES or NO

History of: (circle) Yeast BV Trichomonas Chlamydia Herpes Gonorrhea HPV HIV Genital Warts Hepatitis PID

Date of last Mammogram _____ Date of last DEXA _____ Date of last Colonoscopy _____

Menopausal History: If menopausal, age menopause began: _____ Hot Flashes: Yes or No Night Sweats: Yes or No

Hormone therapy: Yes or No Other Treatment: _____

OB/GYN History: # of times pregnant: _____ Premature Babies: # _____ Abortions: # _____ Miscarriages: # _____

Ectopic: # _____ Still Birth: # _____ C-Sections: # _____ Vaginal Deliveries: # _____

Social History: Occupation _____ Marital Status: (circle) Married Single Divorced Separated Widow

Education Level: (circle) less than 8th grade 8 9 10 11 12 some college 2 yr college 4 yr college post graduate

General Stress Level: (circle) Low Medium High Exercise Level: (circle) None Occasional Moderate Heavy

Illicit Drugs: Yes or No if YES which drugs _____

Smoke: Yes or No or Quit if YES how much _____ for how long _____ if Quit when _____

Alcohol: (circle) None Occasional Moderate Heavy Have you ever felt the need to cut down on drinking: YES or NO

Sexually Active: YES or NO or VIRGIN Sexual Orientation: Heterosexual Homosexual Bisexual

Number of Sexual Partners (lifetime) _____

Any changes in your relationship: YES or NO

Do you feel safe in your relationship: YES or NO.

Surgical History: 1. _____ Yr. _____ 2. _____ Yr. _____ 3. _____ Yr. _____

4. _____ Yr. _____ 5. _____ Yr. _____ 6. _____ Yr. _____

Family History: Please list your family members who have had any of the following using the following abbreviations:

M=Mother, **F**=Father, **S**=Sister, **B**=Brother, **MGM**=Mother's mother, **MGF**=Mother's father, **MA**=Mother's sister

PGM=Father's mother, **PGF**=Father's father, **PA**=Father's sister

_____ Breast Cancer _____ Heart Attack _____ Hyperthyroidism _____ Hypothyroidism _____ Anemia

_____ Ovarian Cancer _____ Stroke _____ Depression _____ Respiratory Disease _____ Anxiety

_____ Uterine Cancer _____ High Cholesterol _____ Liver Disease _____ High Blood Pressure

_____ Cervical Cancer _____ Colon Cancer _____ Diabetes _____ Blood Clots in Legs _____ Heart Problems

_____ Blood Clots in Lungs _____ Other Cancers _____