

PATIENT IDENTIFICATION (Please print)

Patient's Name: _____

Address: _____

Home Telephone No: () _____

Work Telephone No: () _____

Reason for Seeing Doctor _____

Date of Birth: ____ / ____ / ____ Age: _____ Religion: _____

Marital Status: S M D SEP W Race: _____

Education: _____ years Occupation: _____

Employer: _____

Type of Insurance: _____ Policy #: _____

Referring Physician: _____

Primary Physician: _____

1. CURRENT MEDICATIONS None

37. PREGNANCY HISTORY (Complete all information)

# of Pregnancies	# of Premature Births	# of Miscarriages	# of Spontaneous Abortions	# of Induced Abortions	# of Living Children
1					
2					
3					
4					
5					

2. MEDICATION ALLERGY / SENSITIVITY None

List all medications allergic to: _____

MEDICAL HISTORY (Check the appropriate box)

Have you or any members of your family had:

	You	Your Family
3. High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
5. Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
6. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
7. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
8. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
9. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
10. Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
11. Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
12. Stomach, Bowel or Gall Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
13. Kidney or Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
14. AIDS (HIV)	<input type="checkbox"/>	<input type="checkbox"/>
15. Hepatitis (type ____)	<input type="checkbox"/>	<input type="checkbox"/>
16. Anemia or Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>
17. Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
18. Allergies	<input type="checkbox"/>	<input type="checkbox"/>
19. Breast Problems	<input type="checkbox"/>	<input type="checkbox"/>
20. Cancer	<input type="checkbox"/>	<input type="checkbox"/>
21. Infertility	<input type="checkbox"/>	<input type="checkbox"/>
22. Female or Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>
23. Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>
24. Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>
25. Herpes (HSV)	<input type="checkbox"/>	<input type="checkbox"/>
26. Syphilis	<input type="checkbox"/>	<input type="checkbox"/>
27. Birth Defects or Inherited Diseases	<input type="checkbox"/>	<input type="checkbox"/>
28. Sexual Abuse or Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>
29. Other Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>
30. No Known Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>

38. MENSTRUAL HISTORY

First Day of Last ____ / ____ / ____

Menstrual Period

Menarche (Age at First Period)	Interval (No. of Days Between Periods)	Length of Period
_____ years	_____ days	_____ days

Abnormalities: Discharge Excessive Bleeding Pain None

39. CONTRACEPTIVE HISTORY

Type	Dates Used
Oral Contraceptive <input type="checkbox"/>	_____
Type(s) _____ <input type="checkbox"/>	_____
IUD _____ <input type="checkbox"/>	_____
Diaphragm _____ <input type="checkbox"/>	_____
Norplant _____ <input type="checkbox"/>	_____
Sponge _____ <input type="checkbox"/>	_____
Spermicide _____ <input type="checkbox"/>	_____
Condoms _____ <input type="checkbox"/>	_____
Other _____ <input type="checkbox"/>	_____
Sterilization <input type="checkbox"/> Male <input type="checkbox"/> Female	

LIFESTYLE

40. Did your mother take DES or any other hormones when pregnant with you? Yes No

41. Have you ever had a Pap test? Yes No

If Yes: Date of your last Pap test? ____ / ____ / ____

Have you ever had abnormal Pap test results? Yes No

42. Are you sexually active? Yes No

43. Do you have one partner or one many partners? many

44. Is intercourse painful for you? Yes No

45. Do you do a monthly self breast exam? Yes No

46. Have you ever had a mammogram? Yes No

If Yes: Date of your last mammogram? ____ / ____ / ____

47. Do you exercise on a regular basis? ... Yes No

If Yes: Type of exercise _____

Hours per week exercise _____

31. HOSPITALIZATIONS List those operations/serious illnesses that have required hospitalization. If more than six, check this box. Do not include pregnancies here.

Month/Year	Illness or Operation	Complications	
		Yes	No
/ /		<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"/>

SUBSTANCE USE (Check only those you use)

32. Alcohol <input type="checkbox"/>	35. Non-Prescribed Drugs <input type="checkbox"/>
Type _____	Type _____
Amt/day _____	Amt/day _____
33. Tobacco <input type="checkbox"/>	Type _____
Type _____	Amt/day _____
Amt/day _____	36. Street Drugs <input type="checkbox"/>
34. Caffeine <input type="checkbox"/>	Type _____
Type _____	Amt/day _____
Amt/day _____	Type _____
	Amt/day _____

Signature: _____