Name_____ DOB_____ Date_____

Medical History

Main reason for office visit _____
Allergies_____
Primary Care Physician (PCP)_____
PCP Address_____ PCP Phone_____
Pharmacy Name (cross streets)_____ Pharmacy Phone_____

Please completely fill out this section

MENSTRUAL PERIODS

First day of last period_____
Age when you started_____
How many days of bleeding?_____
Length of time from the first day of your period to the start of your next period _____

Which of the following apply to you? (Past or Present)

Painful periods	Y	N
Bleeding between periods	Y	N
Irregular periods	Y	N

BIRTH CONTROL

Current Method_____
Previous method(s)_____

SEXUALITY

You: Male, Female, Both, Other
Your partner(s): Male, Female, Both, Other
Sex at birth (if different from present) _____
Number of present partners _____

Painful intercourse	Y	N
Decreased sexual interest	Y	N

PAP SMEAR

Date of last one_____
Where was it done?_____
History of abnormal Pap_____

PREVENTIVE CARE

Colonoscopy _____
Bone Density _____
Screening Labs _____
Mammogram _____

HPV Vaccine	Y	N

SEXUALLY TRANSMITTED INFECTION (date)

Chlamydia_____
Gonorrhea_____
PID_____
HIV_____
Hepatitis B_____
Hepatitis C_____
Genital warts_____
Herpes _____

REVIEW OF SYSTEMS Are you having any of the following problems **TODAY**?

	Yes	No
Heart Trouble		
Heart Murmurs		
Rheumatic Fever		
Blood Clots (Legs or Lungs)		
High Blood Pressure		
Anemia		
Blood Transfusion		
Elevated Cholesterol		
Chest Pains		
Pneumonia		
TB or Valley Fever		
Gallbladder Problems		
Yellow Jaundice (hepatitis)		
Ulcers		
Bloody Stools or Vomit		
Bowel Habit Changes		
Colitis or Spastic Colon		

	Yes	No
Kidney Infection		
Bladder Infection		
Blood in Urine		
Involuntary urine loss		
Frequent Headaches		
Fainting Spells		
Convulsions		
Thyroid Problems		
Diabetes		
Recent Weight Change		
Breast Problems		
Feeling that pelvic organs are falling out		
Cancer		
Depression		
Psychiatric Care		
Bone Problems		
Muscle Problems		

Name_____ DOB_____ Date_____

Medical History

Non-medical Fees*

Missed appt without 24 hours notice	$75	
Missed surgery without 48 hours notice	$250	
FMLA/STD (charge is per employer)	$75	
Records request		Initials _____
to MD office for continuing care	No charge	
all other		
<50 pages	$45	
>50 pages	+ $20 for each additional 15 pages	
Prescription Refills	No Charge with 72 hours notice	

Remember to allow 10 business days for completion of FMLA and medical records preparation and 3 business days for prescription refills. All other requests are considered rush requests and have a $50 charge. * These fees are your responsibility and are not covered by insurance.

NEW PATIENTS completely fill out this section
ESTABLISHED PATIENTS, update each section below with new events in the last year **OR INDICATE NO CHANGE**

OBSTETRIC HISTORY include **ALL pregnancies**

Birth date	c/s or vaginal	# wks at delivery	Birth wt.	Sex	Hospital	Complications

ACCIDENTS AND SAFETY

Abuse/Violence at home	Y	N
Seatbelt use	Y	N
Bike Helmet use	Y	N
Up to date for routine vaccinations	Y	N
Advanced directive/Living will	Y	N

MEDICAL HISTORY (check all that apply to you)

- ☐ Asthma
- ☐ Diabetes
- ☐ DVT/PE (deep vein thrombosis)
- ☐ Endometriosis
- ☐ Fibroids (leiomyoma)
- ☐ GERD (gastroesophageal reflux)
- ☐ Heart Attack
- ☐ Breast Cancer
- ☐ Ovarian Cancer
- ☐ Colon Cancer
- ☐ Other cancer (Please specify)_____
- ☐ PCOS (polycystic ovary syndrome)
- ☐ High cholesterol (Hypercholesterolemia)
- ☐ high blood pressure (Hypertension)
- ☐ thyroid function too high (Hyperthyroid)
- ☐ thyroid function too low (Hypothyroid)
- ☐ Stroke
- ☐ Other condition (Please specify)_____

PREVIOUS SURGERY/HOSPITALIZATIONS (**NOT** including childbirth)

Year	Surgery	Hospital

Name_____ DOB_____ Date_____

Medical History

HABITS

	Current		Past		
	Yes	No	Yes	No	How much (now or in the past. Quit Date?)
Tobacco use					
Alcohol use					
Injection drug use					
Other drug use					
(specify drug name)					
Caffeine use					
Exercise					
(specify type of exercise)					

MEDICATIONS (if none please write NONE)

Medications (Name and dose)	Vitamins/Herbs/Nutritional Supplements

FAMILY HISTORY(If known, specify which relative and whether on mother or father's side)

Condition	Affected relative	Mother's side	Father's side
☐ **FAMILY HISTORY UNKNOWN**			
Diabetes			
Asthma			
Colon Cancer			
DVT/PE			
Endometriosis			
High cholesterol (Hypercholesterolemia)			
Fibroids (leiomyoma)			
High blood pressure (Hypertension)			
Heart Attack			
Thyroid function too high (Hyperthyroid)			
Thyroid function too low (Hypothyroid)			
Breast Cancer			
Stroke (Cerebrovascular accident)			
Ovarian Cancer			
Other cancer (Please Specify)_____			
Other condition (Please Specify)_____			

_____
Signature