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| **Patient Demographics** |
| **First Name:** | **Middle Initial:** | **Last Name:** | **Nickname:**  |
| **Date of Birth:** | **Marital status:**  **Single Married Widowed Divorced Separated Partnership** |
| **Address:** | **City:**  | **State:** | **Zip:** |
| **Main Phone:** | **Occupation:** | **Email:** |
| **Primary Care Provider:** |
| **Whom may we thank for referring you to our practice?** |

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| **Allergies:** |
| **Allergy:** | **Reaction:** |
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| **Medications:** |
| **Name:** | **Strength:** | **What is it for?** |
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| **Current Medical Issues**Please list any past medical history below with date of onset or diagnosis. Examples includeasthma, diabetes, depression, anxiety, drug or alcohol dependency, high blood pressure, thyroid disease, autoimmune disease, chronic pain, gynecologic disorder |
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| **Family Medical History:** |
| **Type of Cancer** | **Son** | **Daughter** | **Mother** | **Father** | **Paternal Grandmother** | **Paternal Grandfather** | **Maternal Grandmother** | **Maternal Grandfather** |
| **Breast:** |  |  |  |  |  |  |  |  |
| **Ovarian:** |  |  |  |  |  |  |  |  |
| **Colon:** |  |  |  |  |  |  |  |  |

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| **Obstetric History** |
|  **Have never been pregnant** |
| **OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES** |
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|  | **CHILD** |
| **YEAR** | **DURATION PREGNANT** | **HRS OF LABOR** | **TYPE OF DELIVERY** | **COMPLICATIONS MOTHER AND/OR INFANT** | **SEX** | **BIRTH WEIGHT** | **PRESENT HEALTH**  |
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| **Gynecological History:** |
| **First day of last Menstrual Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Duration of bleeding \_\_\_\_\_\_\_\_\_ days** | **Are you sexually active:** |  **Yes**  **No** |
| **Contraception Method:** | **If yes, is your partner:** | **Male** **Female** |
| **Last Pap Smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Abnormal: Yes No** | **If yes, explain:** |
| **Last Mammogram: Yes No** | *Date/Location:* |
| **Last Colonoscopy: Yes No** | *Date/Location:* |
| **Last Bone Density: Yes No** | *Date/Location:* |
| **Cervical Procedures** | **Type:** | **Date:** |
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| **History of Infection/STIs** | **Type:** | **Date:** |
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| **Do you have: (circle)** | **FIBROIDS** | **ENDOMETRIOSIS** | **POLYCYSTIC OVARIES** | **HIGH RISK HPV** |
| **Have you received the Gardasil series Yes No** |
| **Surgical History** | **Type** | **Date** |
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