Name_____ DOB_____ Age_____

Reason For Visit: _____

*****Please answer all questions:*****

Last Menstrual Period: ____/____/____ Last Pap: ____/____/____
Last Colonoscopy: ____/____/____ Last Mammo: ____/____/____ Last Dexa: ____/____/____
Age at First Period: _____ Length Of Period: _____ # of Days Between Periods_____
Any recent changes to your periods? _____
Are You Sexually Active? Y / N
Do you use Birth Control? Y / N Type and/or Name: _____
Do you do reg. Breast Exams? Y / N
# of Pregnancies? ____ #of Deliveries ____ # of Miscarriages/Terminations ____
Would you agree to a blood transfusion, in case of emergency? _____yes _____no

Children Delivered Information;

	DOB	Weight	Sex	Vag or c/sec	Problems?
1.)					
2.)					
3.)					
4.)					

Medical Conditions:
Please list any and all medical conditions you may have

_____ _____
_____ _____
_____ _____
_____ _____

Surgeries	Date of Surg	Doctor's Name
1.)		
2.)		
3.)		
4.)		

Family Medical Conditions

Breast Cancer	MOM	DAD	MGM	MGF	PGM	PGF	AUNTS	UNCLES	SIBLING
Ovarian Cancer	MOM	DAD	MGM	MGF	PGM	PGF	AUNTS	UNCLES	SIBILING
Endometrial Cancer	MOM	DAD	MGM	MGF	PGM	PGF	AUNTS	UNCLES	SIBILING
Hypertension	MOM	DAD	MGM	MGF	PGM	PGF	AUNTS	UNCLES	SIBILING
Diabetes	MOM	DAD	MGM	MGF	PGM	PGF	AUNTS	UNCLES	SIBILING
Alzheimer's	MOM	DAD	MGM	MGF	PGM	PGF	AUNTS	UNCLES	SIBILING
Osteoporosis	MOM	DAD	MGM	MGF	PGM	PGF	AUNTS	UNCLES	SIBILING
Osteopenia	MOM	DAD	MGM	MGF	PGM	PGF	AUNTS	UNCLES	SIBILING
Heart Disease	MOM	DAD	MGM	MGF	PGM	PGF	AUNTS	UNCLES	SIBILING

Other (including Cancer)	Which Family Member
_____	_____
_____	_____
_____	_____
_____	_____

(PLEASE CONTINUE ON BACK)

Are your Immunization Records up to date?

Do you smoke? Y / N If yes, How many Packs Per Day? _____
Did you Quit? Y / N What Year? _____
Do you Drink Alcohol? Y / N Type of Alcohol? _____ # Of Drinks _____
(please circle one) PER DAY / WEEKS / YEAR

Any Recreational Drugs? Y / N
Height: _____

Drug Allergies	Reaction

Medications	Strength	How Taken

Pharmacy Name: _____
Mail in Pharm Name: _____
Pharm phone #: _____
Address (Cross Streets) _____

STOP HERE!! OFFICE USE ONLY!!

Weight: _____

BP: ____ / ____

Tests Needed:

_____

Follow up/RTC Visit:

_____