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PATIENT HISTORY: **DATE:**______________

Name:_____________________________________ Date of Birth:____________________ Age:_____

Marital Status: S_____ M_____ W_____ D_____ Sep_____ Occupation:________________________________

Reason for Today's Visit:____

____

Patient & Family Past Medical History: Please Circle All Of The Following Conditions That Apply To You Or Members Of Your Family. Please Specify Relationship To You.

1. Sudden Wt. Loss/Gain__________________________ 10.Urinary Infections__________________________
2. Headaches/Migraine__________________________ 11. Blood Transfusions__________________________
3. Heart Disease__________________________ 12. Anemia/Blood Disorders__________________________
4. Lung Disorders__________________________ 13. Diabetes__________________________
5. Breast Disease__________________________ 14. Thyroid Disease__________________________
6. Jaundice/Hepatitis__________________________ 15. Cancer: Type__________________________
7. Kidney Disease__________________________ 16. Gastrointestinal Disease__________________________
8. Bowel Disorder__________________________ 17. Arthritis/Joint Pain__________________________
9. Sleep Disorder__________________________ 18. Anxiety/Depression__________________________

List Operations You Have Had:

Year	Operation	Reason
_____	______________________________	______________________________
_____	______________________________	______________________________
_____	______________________________	______________________________

Menstrual History:

Age at first period________First day of your last period____________How long does your period usually last? From________To________Day; Are your periods regular?_______Slightly Irregular?_______Completely irregular?_______(Check One). Do you have vaginal bleeding (spotting) between periods?_____________

With your periods, do you experience: Pain?_____________Cramping?____________Bloating?______________

Have you missed time from work/school in the last six months because of your periods?____________________

OVER

Obstetrical History:

Number of Pregnancies________ Miscarriages________ Abortions_______ Living Children________

Contraceptive History:

Current Method______________________ How Long?_____________ Brand, if Pill_________________

Problems?__________________________ Past Methods:_______________________________________

PLEASE ANSWER THE FOLLOWING:

Have you ever had any sexually transmitted disease?_______Type?_________________________________

Did you or are you receiving treatment?____________Date(s):____________________________________

Do you have abnormal discharge?_____________History of yeast infections?______________________

Do you experience pain during intercourse?________After intercourse?_______Briefly describe type of pain you experience:____

Do you experience pain with urination?______Get up at night to urinate?_____How many times?__________

Do you have a problem with bladder leakage when you cough/sneeze?_________Stand/Walk?______________

Do you do self breast examinations?_________Do you have any nipple discharge?_______Tender or Lumpy Breasts?_____________Concerns?____

Date of last Pelvic Exam?____________Last Pap Test?__________Results Normal?______Abnormal?______

Do you smoke?_______Pks/Day?______Consume Alcohol?_______Drink Coffee?______Cups/Day?______

List Medications and Reason you take routinely (Including over-the-counter medications):

____

____

____

List Medications you are **ALLERGIC** to:____

Do you have a Living Will?__________________ Durable power of attorney?_____________________

Doctor:_________________________________ Nurse:_________________________________