



Patient Name: _____ Today's Date: _____

Address: _____ Age: _____

_____ Date of Birth: _____

Reason for seeing doctor today: _____

Do you have an Advanced Directive / Living Will? Yes No Family Doctor: _____

No Known Allergies Latex Allergy ALLERGIES (Please List): _____

CURRENT MEDICATIONS: List any medications you are taking at this time. Include aspirin, vitamins, laxatives, calcium or herbal supplements, etc.

Current Pharmacy: _____

Name of Drug	Dose (mg, IU, etc.)	Times Taken per Day	Taken For
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

HOSPITALIZATIONS / SURGERIES: (Not for Pregnancies):

Date	Illness or Operation	Complication		Hospital/Surgeon
		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"/>	

PREGNANCY HISTORY: Include all abortions, miscarriages & stillbirths

Number of Pregnancies: _____ Number of Abortions: _____ Number of Miscarriages: _____

Number of Premature Births (<37 weeks): _____ Number of Live Births: _____ Number of Living Children: _____

Preg-nancy	Delivery Date (mm/dd/yyyy)	Weeks Pregnant	Birth Weight	Vaginal	C-section	Sex of Child		Complication
						Male	Female	
1				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Pregnancy Complications: Diabetes Hypertension/High Blood Pressure Preeclampsia/Toxemia Preterm Labor

Any history of depression before or after pregnancy? No Yes If Yes, how were you treated: _____

Patient Name: _____ Birth Date: _____

PERSONAL HISTORY

Menstrual History

Age at first period: _____	Do you have abnormal periods?	Yes	No
Date of first day of last period: _____	Do you have pain with your periods?		
Days between periods (1st day to 1st day): _____	Do you bleed between periods?		
Number of days bleeding with periods: _____	Do you have bleeding after sexual intercourse?		
Birth Control Method: _____	Do you have pain with intercourse?		
Have you ever had sex?: Yes <input type="checkbox"/> No <input type="checkbox"/>	Partners Are: Men <input type="checkbox"/> Women <input type="checkbox"/> Both <input type="checkbox"/>		
Are you Sexually Active?: Yes <input type="checkbox"/> No <input type="checkbox"/>	Number of Partners (Lifetime): _____		

Marital Status: Never married Married Widowed Separated Divorced

Do you smoke or chew tobacco?: Yes No Quit If Yes, how much?: _____ • How long?: _____

Do you drink alcohol?: Yes No Quit • I usually drink: beer wine mixed drinks • How much?: _____

Do you use street drugs?: Yes No Quit • If Yes, how much?: _____ • What kind?: _____

Do you drink caffeine?: Yes No • If Yes, how much?: _____

Do you exercise regularly?: Yes No • If Yes, how often?: _____

Have you been sexually abused, threatened or hurt by anyone? Yes No

Test	Last Test Date	Results		Place / Physician
		Normal	Abnormal	
Pap Smear		<input type="checkbox"/>	<input type="checkbox"/>	
Mammogram		<input type="checkbox"/>	<input type="checkbox"/>	
Cholesterol		<input type="checkbox"/>	<input type="checkbox"/>	
Bone Density		<input type="checkbox"/>	<input type="checkbox"/>	
Colonoscopy		<input type="checkbox"/>	<input type="checkbox"/>	
Pelvic Ultrasound		<input type="checkbox"/>	<input type="checkbox"/>	

Have you ever had:	Yes	No		Yes	No		Yes	No		Yes	No
Chicken Pox			Genital Warts			DES Exposure			Anemia		
Chlamydia			Syphilis			Uterine Malformation			Hay Fever		
Gonorrhea			Trichomonas			Abnormal Pap			Glaucoma		
Herpes			Blood Transfusion			Infertility			Rheumatic Fever		

Check any recent or current health problems.

<input type="checkbox"/> Feeling Tired or Poorly	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Chest pain or Discomfort	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Appetite Abnormal	<input type="checkbox"/> Depression	<input type="checkbox"/> Rapid or Irregular Heart Beat	<input type="checkbox"/> Menstrual Cramping
<input type="checkbox"/> Significant Weight Loss	<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Muscle Aches
<input type="checkbox"/> Significant Weight Gain	<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Nausea	<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Fever	<input type="checkbox"/> Headaches	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Chills	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Earache	<input type="checkbox"/> Constipation	<input type="checkbox"/> Vulvar Itching or Burning
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Bloating	<input type="checkbox"/> Vulvar Pain
<input type="checkbox"/> Intolerance to Heat	<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Indigestion / Heartburn	<input type="checkbox"/> Vulvar Lump or Mass
<input type="checkbox"/> Intolerance to Cold	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Labial Swelling
<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Pain During Urination	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Excessive Sweating	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Vaginal Itching or Burning
<input type="checkbox"/> Loss of Hair	<input type="checkbox"/> Swollen Glands in Neck	<input type="checkbox"/> Burning With Urination	<input type="checkbox"/> Vaginal Pain
<input type="checkbox"/> Numbness	<input type="checkbox"/> Breast Pain	<input type="checkbox"/> Urinary Loss of Control	<input type="checkbox"/> Vaginal Odor
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Pelvic Pain
<input type="checkbox"/> Fainting	<input type="checkbox"/> Nipple Discharge	<input type="checkbox"/> Skin Rash	<input type="checkbox"/> Pelvic Pressure
<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Cough	<input type="checkbox"/> Easy Bleeding	
<input type="checkbox"/> Tremors	<input type="checkbox"/> Shortness of Breath		

Patient Name: _____ Birth Date: _____

SELF AND FAMILY HISTORY

MGM - Maternal Grandmother	MGF - Maternal Grandfather			PGM - Paternal Grandmother		PGF - Paternal Grandfather			
Check ALL that apply.	Self	Mom	Dad	Sis	Bro	MGM	MGF	PGM	PGF
Diabetes type I	<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"/>
Diabetes type II	<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"/>
Hypertension	<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"/>
Stroke	<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"/>
Blood clots in legs	<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"/>
Blood clots in lungs	<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"/>
Heart disease	<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"/>
Heart attack	<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"/>
High cholesterol	<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"/>
Thyroid problems	<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"/>
Rheumatoid arthritis	<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"/>
Lupus	<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"/>
Osteoporosis	<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"/>
Varicose veins	<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"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Birth defects	<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"/>
Multiple gestation	<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"/>
Problems with anesthesia	<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"/>
Kidney problems	<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"/>
Frequent UTI	<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"/>
Liver disease	<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"/>
Hepatitis	<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"/>
HIV / AIDS	<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"/>
Neurologic problems	<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"/>
Mental illness	<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"/>
Anxiety	<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"/>
Depression	<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"/>
Dementia	<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"/>
Seizures / Epilepsy	<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"/>
Migraines	<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"/>
Asthma	<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"/>
Tuberculosis (TB)	<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"/>
Lung problems	<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"/>
Digestive problems	<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"/>
Breast cancer	<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"/>
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Uterine cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cervical cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Colon cancer	<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"/>
Liver cancer	<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"/>
Thyroid cancer	<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"/>
Lung cancer	<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"/>
Other cancer	<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"/>

Patient Adopted - No FHx

Other Patient History: _____

Other Family History: _____

Patient Name: _____ Birth Date: _____

**IF YOU ARE PREGNANT
PLEASE COMPLETE THE REMAINDER OF THIS FORM**

GENETICS SCREENING

Includes patient, baby's father, or anyone in either family with:

	YES	NO
1. Patient's age 35 years or older	<input type="checkbox"/>	<input type="checkbox"/>
2. Thalassemia (Italian, Greek, Mediterranean, or Asian Background)	<input type="checkbox"/>	<input type="checkbox"/>
3. Neural tube defect (Meningomyelocele, Spina Bifida, or Anencephaly)	<input type="checkbox"/>	<input type="checkbox"/>
4. Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
5. Tay-Sachs (eg. Jewish, Cajun, Fr. Canadian)	<input type="checkbox"/>	<input type="checkbox"/>
6. Sickle Cell Disease or Trait (African)	<input type="checkbox"/>	<input type="checkbox"/>
7. Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
8. Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
9. Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>
10. Huntington's Chorea	<input type="checkbox"/>	<input type="checkbox"/>
11. Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>
If yes, was person tested for Fragile X?	<input type="checkbox"/>	<input type="checkbox"/>
12. Other inherited genetic or chromosomal disorder	<input type="checkbox"/>	<input type="checkbox"/>
13. Patient or baby's father had a child with birth defects not listed above	<input type="checkbox"/>	<input type="checkbox"/>
14. Spontaneous miscarriage or a stillbirth	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you used Medications/Street drugs/Alcohol since last menstrual period	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list agent(s): _____		
16. Any other genetic problems: _____	<input type="checkbox"/>	<input type="checkbox"/>

INFECTION HISTORY: Patient Only

	YES	NO
1. Do you have any reason to believe you are high risk for HIV?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any reason to believe you are high risk for Hepatitis B?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been immunized against Hepatitis B?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you live with someone with TB or exposed to TB?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you or your partner have a history of genital herpes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had a rash or viral illness since your last menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have a history of sexually transmitted diseases (Gonorrhea, Chlamydia, Warts, Syphilis)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any history of Pelvic Inflammatory Disease (PID) or infections of your tubes or ovaries?	<input type="checkbox"/>	<input type="checkbox"/>

Have you had any problems with this pregnancy (bleeding, cramping, headaches, visual problems, backache, vaginal drainage?)
