**********PLEASE FILL THIS OUT COMPLETELY**********

Name: _____ Age_____ Date_____
Reason for today's visit: _____
Who referred you to us: _____
Number of Pregnancies: _____ Deliveries _____ Miscarriages _____ Abortions _____ Living Children _____
First day of last period: _____ Are your periods regular: _____
Do you have any problems with your period:_____ If so, please explain:_____
Are you menopausal: _____ Any related problems: _____
Present type of birth control (circle one): Condoms ☐ Pills ☐ IUD ☐ Nexplanon ☐ Tubal Ligation ☐ Vasectomy ☐ Other ☐ None ☐
Do you want to change birth control methods: _____ If so, to what:_____

GYNECOLOGICAL HISTORY – CIRCLE ALL THAT YOU HAVE/HAD

Abnormal Bleeding ☐ Herpes Infection ☐ Tubal (ectopic) Pregnancy ☐ Endometriosis ☐
Chlamydia/Gonorrhea/Syphilis ☐ Genital Warts ☐ HPV ☐ Pelvic Infection ☐
Infection of the tubes or ovaries ☐ Tumor of the uterus ☐ Ovarian Cysts ☐ Fibroids ☐
Pelvic Pain ☐
Abnormal Pap Smear ☐ Cryo ☐ LEEP ☐ Cervical Conization ☐
If you circled any of the above, what treatment was done:_____

MEDICAL HISTORY – CIRCLE ALL THAT APPLY

Arthritis ☐ Hepatitis ☐ Migraines ☐ Rheumatic Fever ☐ Asthma ☐
Seasonal Allergies ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes ☐ Thrombophlebitis ☐
Breast Tumor ☐ Hypo/HyperThyroidism ☐ Heart Disease ☐ Heart Attack ☐ Mitral Valve Prolapse ☐
SVT ☐ Heart Murmur ☐ Intestinal Bleeding ☐ Acid Reflux/GERD ☐ Pneumonia ☐
Neurological Disease ☐ Osteoporosis ☐ Kidney Infection ☐ Kidney Disease ☐ Kidney Stones ☐
Anxiety ☐ Depression ☐
Other:_____
Infectious Disease (TB, HIV, etc)_____

MEDICAL HISTORY – CONTINUED

Cancer _____
Type/When Diagnosed_____
Treatment:_____

MEDICATION ALLERGIES/REACTION

_____
_____

MEDICATIONS – List all medications you take, with dose and frequency, over the counter medications as well as prescription

_____
_____
_____

SURGICAL HISTORY – NAME & DATE OF SURGERY

1._____ 2._____
3. _____ 4. _____
5. _____ 6._____

OBSTETRICAL HISTORY

DATE	SEX	TYPE OF DELIVERY	WEIGHT OF BABY	COMPLICATIONS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FAMILY CANCER HISTORY:

Breast Who_____ Maternal_____ Paternal_____

Ovarian Who_____ Maternal_____ Paternal_____

Uterus Who_____ Maternal_____ Paternal_____

Colon Who_____ Maternal_____ Paternal_____

Other
Type_____ Who_____ Maternal _____ Paternal_____

SOCIAL
Marital Status (circle) Single☐ Married☐ Divorced☐ Widowed☐ Separated☐
Race: _____ Occupation:_____
Do you drink alcohol?_____ If yes, estimated number of drinks, beers, glasses of wine per week?_____
Do you smoke?_____ If yes, how many cigarettes a day?_____
Did you smoke previously?_____ If yes, when did you quit?_____
Are you using any illegal drugs?_____ What type?_____
Are you sexually active?_____ Any difficulties or discomfort?_____

Date of last Pap Smear _____ **Result**_____
Date of last Mammogram_____ **Result**_____
Date of last Bone Density_____ **Result**_____
Date of last Colonoscopy_____ **Result**_____

Pharmacy Name and Phone Number_____
Do you need a one month or 90 day prescription?_____

Did you get the COVID Vaccine, if so, when did you receive your vaccines (please list dates)_____
_____

Have you had COVID? If yes, when did you have COVID?_____