



Patient Information

Please help us by giving some information about your health.
Please complete both sides.

Name _____ Birthday _____ Age _____ Date _____

Primary Care Doctor _____ Referred by _____

Permission to release records to my Primary Doctor: Yes _____ No _____

Signature: _____

Preferred method of contact with test results _____

(Cell phone number _____)

Reason for your visit _____

Current Medications _____

Allergies _____

Date of last period _____ Number of days of flow _____

How many days between periods _____ Age when periods began _____

How heavy are your periods _____

Any history of sexually transmitted diseases _____

Date of last pap smear _____ Date of last Mammogram _____

Date of last colonoscopy _____ Date of last bone density scan (DXA) _____

When was the last time you were sexually active _____ Method of birth control _____

If you are between the ages of 9 and 26, have you had Gardasil injections? Yes _____ No _____

If yes, how many Gardasil injections have you had? _____

Any history of abuse _____ Any history of rape _____

Number of prior pregnancies _____ Number of children _____

Number of vaginal deliveries _____ Number of C-Sections _____

Complications _____

Do you smoke _____ Amount _____ Do you drink alcohol _____ Amount _____

Have you ever used drugs _____ Do you exercise _____ Do you use a seat belt _____

What type of work do you do _____

Medical health problems (such as diabetes, high blood pressure, thyroid problems or problems with heart, lung or kidney)?

Any past surgeries?

OVER →

OVER →

OVER →

OVER →

OVER →

Family Health Problems:

Review the following list of health problems and check yes if they apply to parents, grandparents, brothers, sisters, aunts, uncles, or your children.

| | No | Yes | Relation | Age when diagnosed |
|---------------------|----|-----|----------|--------------------|
| Diabetes | | | | |
| Heart Disease | | | | |
| Osteoporosis | | | | |
| High Blood Pressure | | | | |
| Stroke | | | | |
| Blood clots | | | | |
| Colon cancer | | | | |
| Breast cancer | | | | |
| Ovarian cancer | | | | |
| Endometrial cancer | | | | |

Have there been any changes in the last year?

Regarding your health, please review the following list of health problems and describe any "yes" answers:

| | No | Yes | Describe | | No | Yes | Describe |
|---------------------------|----|-----|----------|---------------------|----|-----|----------|
| Weight loss | | | | Pain in muscles | | | |
| Weight gain | | | | Pain in joints | | | |
| Vision changes | | | | Breast pain | | | |
| Hearing loss | | | | Nipple Discharge | | | |
| Sinus problems | | | | Breast lumps | | | |
| Chest pain | | | | Skin rash | | | |
| Difficulty breathing | | | | Moles | | | |
| Swelling in legs | | | | Dry skin | | | |
| Irregular heartbeat | | | | Fainting | | | |
| Shortness of breath | | | | Dizziness | | | |
| Chronic cough | | | | Seizures | | | |
| Blood in the sputum | | | | Headaches | | | |
| Diarrhea | | | | Memory problems | | | |
| Blood in stool | | | | Depression | | | |
| Constipation | | | | Anxiety | | | |
| Nausea or Vomiting | | | | Hair loss | | | |
| Problems with urination | | | | Hot flashes | | | |
| Urgency | | | | Thyroid problems | | | |
| Frequency | | | | Diabetes | | | |
| Involuntary loss of urine | | | | Easy bruising | | | |
| Blood in urine | | | | Bleeding | | | |
| Pain with urination | | | | Pain | | | |
| Vaginal discharge | | | | Pain w/ intercourse | | | |