

Name: _____ Age: _____ DOB: _____ Today's Date: _____

What concerns or problems would you like to discuss with your doctor today?

Personal History

Place of Employment _____	Do you exercise? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Job Title _____	Are you on a diet? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Married/Single/Divorced/Widow _____	Have you ever smoked/How much? <input type="checkbox"/> Y <input type="checkbox"/> N _____
I live with _____	Do you drink alcohol/How often <input type="checkbox"/> Y <input type="checkbox"/> N _____
Next of Kin Name: _____	Caffeine beverages (cups/day) <input type="checkbox"/> Y <input type="checkbox"/> N _____
Next of Kin Phone Number: _____	Any history of drug abuse? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Referring/Primary Care MD _____	Sexual abuse <input type="checkbox"/> Y <input type="checkbox"/> N _____
	Violent relationships <input type="checkbox"/> Y <input type="checkbox"/> N _____
Have you ever been tested for HIV? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Would you like to be tested for HIV? <input type="checkbox"/> Y <input type="checkbox"/> N _____

Do you have a history of any of the following?

Weight loss/fatigue <input type="checkbox"/> Y <input type="checkbox"/> N _____	UTI/Kidney Disease <input type="checkbox"/> Y <input type="checkbox"/> N _____
Ear, Nose, Throat Problems <input type="checkbox"/> Y <input type="checkbox"/> N _____	Spine/Hip/knee problem <input type="checkbox"/> Y <input type="checkbox"/> N _____
High blood pressure/stroke <input type="checkbox"/> Y <input type="checkbox"/> N _____	Skin problems <input type="checkbox"/> Y <input type="checkbox"/> N _____
Blood clots in legs <input type="checkbox"/> Y <input type="checkbox"/> N _____	Seizures/Epilepsy <input type="checkbox"/> Y <input type="checkbox"/> N _____
Heart disease/murmur <input type="checkbox"/> Y <input type="checkbox"/> N _____	Migraine/headaches <input type="checkbox"/> Y <input type="checkbox"/> N _____
Asthma/pneumonia <input type="checkbox"/> Y <input type="checkbox"/> N _____	Thyroid Disease <input type="checkbox"/> Y <input type="checkbox"/> N _____
Stomach ulcer <input type="checkbox"/> Y <input type="checkbox"/> N _____	Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N _____
Diarrhea/constipation/irritable bowel <input type="checkbox"/> Y <input type="checkbox"/> N _____	Easy bleeding/bruising <input type="checkbox"/> Y <input type="checkbox"/> N _____
Jaundice/hepatitis/liver disease <input type="checkbox"/> Y <input type="checkbox"/> N _____	Blood transfusion <input type="checkbox"/> Y <input type="checkbox"/> N _____
Gallbladder problem <input type="checkbox"/> Y <input type="checkbox"/> N _____	Depression <input type="checkbox"/> Y <input type="checkbox"/> N _____

Physician Notes

Family History ... (Please note your relative)

Heart disease/Heart attack <input type="checkbox"/> Y <input type="checkbox"/> N _____	Age at time of MI _____	Blood clots in the legs <input type="checkbox"/> Y <input type="checkbox"/> N _____
High blood pressure/Stroke <input type="checkbox"/> Y <input type="checkbox"/> N _____		Cervical cancer <input type="checkbox"/> Y <input type="checkbox"/> N _____
High cholesterol <input type="checkbox"/> Y <input type="checkbox"/> N _____		Anemia <input type="checkbox"/> Y <input type="checkbox"/> N _____
Alzheimer's disease <input type="checkbox"/> Y <input type="checkbox"/> N _____		Blood Disorder <input type="checkbox"/> Y <input type="checkbox"/> N _____
Seizures/Epilepsy <input type="checkbox"/> Y <input type="checkbox"/> N _____		Birth defects <input type="checkbox"/> Y <input type="checkbox"/> N _____
Breast cancer <input type="checkbox"/> Y <input type="checkbox"/> N _____	Age at time of diagnosis: _____	Osteoporosis <input type="checkbox"/> Y <input type="checkbox"/> N _____
Ovarian cancer <input type="checkbox"/> Y <input type="checkbox"/> N _____	Age at time of diagnosis _____	Thyroid disease <input type="checkbox"/> Y <input type="checkbox"/> N _____
Uterine (endometrial) cancer <input type="checkbox"/> Y <input type="checkbox"/> N _____		Colon cancer/Polyps <input type="checkbox"/> Y <input type="checkbox"/> N _____
Easy Bleeding/Bruising <input type="checkbox"/> Y <input type="checkbox"/> N _____		Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N _____

Physician Notes

Do you have any religious or personal beliefs against blood transfusions or blood products? Y N

Gynecological History

Last menstrual period _____ Age periods began _____ Length of cycle _____
 Currently sexually active? Yes No Partner (circle): Male Female # Sex partners in lifetime: _____

Name: _____ **Age:** _____ **DOB:** _____ **Today's Date:** _____

Age of first sexual intercourse _____ Current method of birth control? _____

Have you ever used BC pills?/ How Long? _____

Date of Last Pap Smear/ Result _____

Pregnancy History			
Number of times pregnant:	# of Abortions:	# of Miscarriages:	# of Children:
Delivery Year	Type of Delivery (Vaginal or C-Section)	Baby's Birth Weight	Pregnancy/Delivery Complications

Gynecological History – Have you ever had: (Please Include Dates)							
Abnormal pap smear	<input type="checkbox"/>	Y	<input type="checkbox"/>	Colposcopy/Cryosurgery/Laser Surgery	<input type="checkbox"/>	Y	<input type="checkbox"/>
Pelvic inflammatory disease (PID)	<input type="checkbox"/>	Y	<input type="checkbox"/>	Warts/Herpes/Chlamydia/Gonorrhea/Syphilis	<input type="checkbox"/>	Y	<input type="checkbox"/>
Pain with intercourse	<input type="checkbox"/>	Y	<input type="checkbox"/>	Vaginal dryness	<input type="checkbox"/>	Y	<input type="checkbox"/>
Leakage of urine	<input type="checkbox"/>	Y	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	Y	<input type="checkbox"/>
Yeast infections	<input type="checkbox"/>	Y	<input type="checkbox"/>	DES Exposure before birth	<input type="checkbox"/>	Y	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	Y	<input type="checkbox"/>	Surgery on ovaries	<input type="checkbox"/>	Y	<input type="checkbox"/>
Ovarian cysts	<input type="checkbox"/>	Y	<input type="checkbox"/>	Breast disease	<input type="checkbox"/>	Y	<input type="checkbox"/>
Uterine fibroids	<input type="checkbox"/>	Y	<input type="checkbox"/>	Breast Surgery	<input type="checkbox"/>	Y	<input type="checkbox"/>
Cervical cancer	<input type="checkbox"/>	Y	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	Y	<input type="checkbox"/>
Uterine Cancer	<input type="checkbox"/>	Y	<input type="checkbox"/>	Ovarian cancer	<input type="checkbox"/>	Y	<input type="checkbox"/>
Date of last mammogram: _____	Where? _____	_____	_____	Abnormal/Irregular Vaginal Bleeding	<input type="checkbox"/>	Y	<input type="checkbox"/>
Date of last Dexascan Test _____	Where? _____	_____	_____				

Physician Notes:

Please list all your surgeries/hospitalizations (Years/Procedures)

Current Medications (Include doses)	Allergies to Medications (include reactions)

Last Lab Testing	Date	Results	Immunizations
Cholesterol	_____	_____	Rubella
Fasting blood sugar	_____	_____	Influenza
Fecal Occult blood test	_____	_____	Tetanus
Sigmoidoscopy/Colonoscopy	_____	_____	Pneumovax
Dexascan	_____	_____	Hepatitis B

Name: _____		Age: _____	G P _____	Date: _____	Allergies: _____
HT: _____	WT: _____	BMI: _____	BP: _____	Temp: _____	Pulse: _____
Respirations: _____	Medications: _____				
LMP _____	BCM _____	Last Pap Result: _____	Last Mammogram: _____	Last Colonoscopy: _____	

History of Present Illness

EXAM

General Appearance: Well developed Well nourished Normal mood/affect Oriented x 3 No acute distress

Neck Supple Without masses Without thyromegaly

Breast No dominant masses No skin changes No nipple discharge

Lungs Clear to auscultation bilaterally Normal respiratory effort

Heart Regular rhythm and rate No murmurs/gallops

Abdomen Soft, non-distended No masses/HSM No Hernias

Back No CVA tenderness

Skin No lesions No abnormal moles

Lymphatic No neck No axillare No groin lymphadenopathy

Extremities Without varicosities Without edema Nontender calves

Pelvic Exam Normal external genitalia

Urethral meatus/urethra Without lesions, tenderness or prolapse

Bladder Without masses, tenderness Well supported

Vagina Well supported No lesions No abnormal discharge

Cervix Without lesions No CMT

Uterus Position: Normal size & shape Nontender Without descent

Adnexa Normal size No adnexal masses No tenderness

Anus/Perineum No lesions

Rectal: Normal sphincter tone No hemorrhoids No tenderness

Other findings: _____

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Fecal Occult	Neg	Pos	Instructions:
Blood Work	NL	Other	Instructions:
Cultures	NL	Other	Instructions:
Notified by	Mail	Phone	Sig:
Patient in recall for:			
Notes:			