



Name \_\_\_\_\_ DOB \_\_\_\_\_

WELCOME TO OUR PRACTICE  
PATIENT MEDICAL INFORMATION

Date: \_\_\_\_\_

AGE \_\_\_\_\_ LAST MENSTRUAL PERIOD BEGAN ON \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

OBSTETRICAL HISTORY

YEAR	DELIVERY TYPE	WEIGHT	WEEKS	MALE OR FEMALE	NAME	COMPLICATIONS

GYNECOLOGIC HISTORY

Age of first period \_\_\_\_\_ # of days between periods \_\_\_\_\_ # of flow days \_\_\_\_\_

Last Pap \_\_\_\_\_ Date & treatment for abnormal paps \_\_\_\_\_ Have you had the HPV vaccine? \_\_\_\_\_

Do you do self-breast exams? \_\_\_\_\_ Any family history of breast cancer? \_\_\_\_\_

Last mammogram \_\_\_\_\_ Date & treatment of abnormal mammogram \_\_\_\_\_

Have you ever been sexually active? \_\_\_\_\_ Are you sexually active now? \_\_\_\_\_ Birth control method \_\_\_\_\_

Any history of sexually transmitted infections? \_\_\_\_\_

Any history of abuse? (verbal, sexual, or physical) \_\_\_\_\_

Do you leak urine with coughing or sneezing? \_\_\_\_\_ at rest? \_\_\_\_\_ with urge? \_\_\_\_\_

DRUG ALLERGIES \_\_\_\_\_

MEDICATIONS	STRENGTH	DOSAGE SCHEDULE

MEDICAL HISTORY (please include all previous diagnoses, whether big or small)

\_\_\_\_\_

\_\_\_\_\_

SURGICAL HISTORY (please include date of all previous surgeries, big and small)

\_\_\_\_\_

\_\_\_\_\_

(Please fill out front and back)

Name \_\_\_\_\_ DOB \_\_\_\_\_

## SOCIAL HISTORY

Have you ever smoked? \_\_\_\_\_ How much per day, now? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you currently or do you have a past history of illicit drug use? \_\_\_\_\_

Do you use alcohol? \_\_\_\_\_ If so, how much do you drink daily or weekly? \_\_\_\_\_

Have you ever had a blood transfusion? \_\_\_\_\_ If so, when? \_\_\_\_\_

Are you single or married? \_\_\_\_\_

## REVIEW OF SYSTEMS (please circle if you are feeling any of the following symptoms today)

Constitutional: Feeling tired or poorly, fever, chills, recent weight loss, recent weight gain

Chest: Chest pain or discomfort, shortness of breath, palpitations, cough, difficulty breathing

GI: Abdominal pain, nausea, vomiting, diarrhea, constipation, heartburn, decreased appetite

Skin/musculoskeletal: Rash, joint pain, back pain

Heme/endocrine: Easy bruising, excessive sweating, night sweats, excessive thirst, temperature intolerance

Neuro: Headache, migraines, ringing in ears, sleep disturbances, depression, anxiety

Ear, Nose, Throat: Nasal congestion, nose bleeds, difficulty swallowing, sore throat, hoarseness

Urinary: Pain with urination, increased frequency of urination, blood in urine, leaking urine

Gynecologic: Abnormal vaginal discharge, itching, irritation, irregular bleeding, unexplained vaginal bleeding, heavy menstrual periods, painful menstrual cramps, pelvic pain, pain with intercourse, post-menopausal bleeding

OTHER: \_\_\_\_\_

**FAMILY HISTORY** (Heart problems, prolonged bleeding, stroke, diabetes, high blood pressure, congenital birth defects, cancers, etc....) \_\_\_\_\_

THANK YOU SO MUCH FOR COMPLETING THIS FORM SO WE CAN TAKE BETTER CARE OF YOU!!!

Is there any additional information you would like to share? \_\_\_\_\_

## OFFICE USE BELOW PLEASE

Wt \_\_\_\_\_ Ht \_\_\_\_\_ BMI \_\_\_\_\_ BP \_\_\_\_\_ P \_\_\_\_\_ T \_\_\_\_\_ R \_\_\_\_\_

Urinalysis \_\_\_\_\_ UPT \_\_\_\_\_ HPV indicated? \_\_\_\_\_ Ordered? \_\_\_\_\_

ASSESSMENT/PLAN \_\_\_\_\_

Signed \_\_\_\_\_

Return to Office \_\_\_\_\_