Date: _____ **Referred By:** _____ **Primary M.D**._____

Name: _____ **Age**: _____ **Phone #:** (_____) _____

Number of Pregnancies: _____ Children: _____ Miscarriages: _____ Abortions: _____ Last Period: ___/___/_____

What is the reason for this visit? _____

PAST MEDICAL HISTORY:

Operations_____

Other Hospitalizations_____

Current Medications_____

Allergies_____

Have you ever smoked? Yes / No Cigarettes per day? _____ Illicit Drugs? _____

Alcoholic drinks per day? Wine: _____ Beer: _____ Liquor: _____

Contraceptive (birth control) Method _____

FAMILY HISTORY: Has anyone in your family (parent, brother/sister, grandparent, aunt/uncle) had any of the following? Cancer, Diabetes, High Blood Pressure, Heart Disease, Mental Retardation, Birth Defects, Twins, Anemia, Psychosis, Other?

****Please indicate if the family member is on your mother's or your father's side of the family****

Family Member	Condition	Family Member	Condition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SYSTEM REVIEW: Have you had any of the following problems?

GYN	**Yes**	**No**
Menstrual Problems	___	___
Pelvic Pain	___	___
Infections: Herpes	___	___
Chlamydia	___	___
Other	___	___
Sexual Concerns	___	___
Urine Loss	___	___
Urine Infection	___	___
Pain with urination	___	___
Abnormal Pap Smear	___	___
Condyloma (warts)	___	___
Mother took D.E.S.	___	___
HEENT		
Hearing / Ear Problems	___	___
Eye / Vision Problems	___	___
Headache (frequent / severe)	___	___
PSYCHOSOCIAL		
Emotional	___	___
Physical / Emotional Abuse	___	___

CARDIO/PULM	**Yes**	**No**
Asthma	___	___
Pneumonia	___	___
High Blood Pressure	___	___
Heart Disease	___	___
ENDOCRINE		
Thyroid	___	___
Other	___	___
GASTROINTESTINAL		
Bowel Problems	___	___
Weight Changes	___	___
Abdominal Pain	___	___
Blood in Stool	___	___
MUSCULOSKELETAL		
Joint Pain	___	___
Back Pain	___	___
Weakness / Tiredness	___	___

Other: _____

_____

_____