

Name: _____ Date Of Birth: _____

Date completed: _____

Reason for visit: _____

Preferred Pharmacy Name/City: _____

Preferred Lab (contracted with your insurance plan) for bloodwork or specimen testing: _____

MENSTRUAL HISTORY

Still having periods, please answer the following: Date of your last menstrual period _____

Do you have pain associated with your periods? No Yes Occasionally

What age did you have your first period? _____

No longer having periods, please answer the following: At what age did you stop having periods? _____

Have you had a hysterectomy? No Yes, what year? _____

Type of hysterectomy: _____ Were your ovaries removed? No Yes

Are you taking or have taken hormone therapy? No Yes, in the past Yes, currently taking

CONTRACEPTION (Skip section if no longer having periods)

What is your current method of birth control: _____

Are you satisfied with your current method? No Yes Do you want to change? No Yes

Are you thinking of conceiving in the next year? No Yes

SEXUAL HEALTH

Are you sexually active? No Yes Partner Gender: Male Female Both

Have you had the Human Papilloma Virus Immunization (Gardasil)? No Yes, please complete next line

Last injection date: _____ Series: completed started

PREVENTATIVE HEALTH HISTORY

Over the past 2 weeks, how often have you been bothered by any of the following:

- | | | | | |
|--|----------------|------------------|-----------------------------|----------------------|
| 1. little interest or pleasure in doing things | Not at all (0) | Several days (1) | More than half the days (2) | Nearly every day (3) |
| 2. feeling down, depressed or hopeless | Not at all (0) | Several days (1) | More than half the days (2) | Nearly every day (3) |

21 years of age and older: Date of your last Pap Smear _____ Was it normal? No Yes

Have you ever had an abnormal pap smear? No Yes What year? _____

Have you ever had a colposcopy for an abnormal pap smear? No Yes

Have you had treatment for abnormal pap smear? No Yes, when: _____

Treatment type performed: Cryotherapy LEEP Cone Biopsy

40 years of age and older: Date of your last Mammogram _____ N/A

Have you ever had an abnormal mammogram? No Yes

Have you ever had breast implants? No Yes When: Current Past (removed)

Implant Type: Silicone Saline Both types

Do you perform regular breast self examinations? No Yes

50 years of age or older Date of your last Colonoscopy _____ N/A

65 years of age or older Date of your last Dexa/bone scan _____ N/A

PREGNANCY HISTORY

How many times have you been pregnant? _____ How many children do you have? _____
 How many deliveries were Vaginal _____ Cesarean Sections _____ VBAC _____
 How many pregnancies were Miscarriages _____ Abortions _____ Ectopic _____

Month/Year	Birth Weight	Sex	Weeks Pregnant	Type of Birth	Complications

MEDICAL HISTORY- Check all that apply for past or present conditions None

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal Uterine Bleeding | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Obstructive Sleep Apnea |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Fecal Incontinence | <input type="checkbox"/> Pain with intercourse |
| <input type="checkbox"/> Alzheimer’s | <input type="checkbox"/> Genital warts | <input type="checkbox"/> Pelvic Inflammatory disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Polycystic Ovary Syndrome |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Problem with periods |
| <input type="checkbox"/> Aortic Stenosis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Renal Insufficiency or |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Recurrent Bladder Infections |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Cancer Type: _____ | <input type="checkbox"/> HIV | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> HPV | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease | <input type="checkbox"/> Infertility | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Ulcers or H pylori |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Low thyroid | <input type="checkbox"/> Uterine cramps |
| <input type="checkbox"/> Diabetes treated with insulin | <input type="checkbox"/> Obesity | <input type="checkbox"/> Uterine Fibroids |
| <input type="checkbox"/> Diabetes treated with pills | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Deep Vein Thrombosis/blood clot | <input type="checkbox"/> Other: _____ | |

SURGICAL HISTORY

- | | | | | | | |
|-----------------------|-------|---------------------|-------|-------------------------------|-------|------|
| | Year | | Year | <input type="checkbox"/> None | | Year |
| Tonsillectomy | _____ | Appendectomy | _____ | D&C (miscarriage) | _____ | |
| Cardiac Catherization | _____ | Tummy tuck | _____ | D&C (bleeding) | _____ | |
| Heart Surgery (CABG) | _____ | Gastric bypass | _____ | Hysterectomy | _____ | |
| Breast biopsy | _____ | Colonoscopy (polyp) | _____ | Myomectomy | _____ | |
| Breast implants | _____ | laparoscopy | _____ | Uterine ablation | _____ | |
| Abdominal Surgery | _____ | C-section | _____ | LEEP/Cone biopsy | _____ | |
| Hernia repair | _____ | Tubal Ligation | _____ | Other: | _____ | |

FAMILY HISTORY

Unknown/Adopted

List any medical conditions that your family has:

Mother: _____

Father: _____

Sister: _____

Sister: _____

Brother: _____

Brother: _____

Any other family member with: *Please state relationship (ex. maternal aunt, paternal grandmother)*

Breast Cancer: _____

Ovarian Cancer: _____

Colon Cancer: _____

MENTAL HEALTH HISTORY

Have you ever been diagnosed with Anxiety? No Yes, please answer next question

Have you been treated by (check all applicable): Therapist Psychiatrist Medications Not treated

Have you ever been diagnosed with Depression? No Yes, please answer next question

Have you been treated by (check all applicable): Therapist Psychiatrist Medications Not treated

Have you ever been diagnosed with any mental health condition? No Yes, please answer next question

If yes please list diagnosis _____

Have you been treated by (check all applicable): Therapist Psychiatrist Medications Not treated

SOCIAL HISTORY

Tobacco Use Never Current Former year quit: _____

Please answer additional questions for current or former user

Type: Cigarettes Pipe Cigars

How many packs/per day _____ Number of yrs smoked _____

Smokeless Tobacco Use Never Current Former year quit: _____

Type: Snuff Chew

Alcohol Use Never Daily Socially Drinks per week: _____

Recreational Drug Use Never Current Former year quit: _____

Please answer additional questions for current or former user

Type: Marijuana Methamphetamine Ecstasy Heroin

Cocaine IV Prescription Drugs Other: _____

E-Cigarette Use Never Current Former year quit: _____

Has anyone forced you to have sexual activities that made you feel uncomfortable? No Yes

Are you in a relationship with a person who threatens or physically hurts you? No Yes

ALLERGIES

Do you have nut (food) allergy? No Yes

Do you have medication/drug allergies? No Yes, please list below with the reaction

Drug Name	Reaction

Drug Name	Reaction

MEDICATIONS

Are you taking any prescribed medications? No Yes, please list below:

Medication Name	Dose/Strength	How do you take it?

Are you taking non-prescribed or over the counter medications? No Yes, please list below:

Name

Name

STEAD! If you are 65 years of age or older, please answer the following:

N/A

Did you fall anytime in the past year? No Yes

Do you feel unsteady when standing or walking? No Yes

Do you worry about falling? No Yes

If completing form by computer, please save your responses and send us a MyHealth message and attach the file (PDF only). Otherwise please return completed form to the receptionist. Thank you.