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 were 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**

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

SURGICAL HISTORY □ **None**

	Year
Tonsillectomy	___________
Cardiac Catherization	___________
Heart Surgery (CABG)	___________
Breast biopsy	___________
Breast implants	___________
Abdominal Surgery	___________
Hernia repair	___________
Appendectomy	________
Tummy tuck	________
Gastric bypass	________
Colonoscopy (polyp)	________
laparoscopy	________
C-section	________
Tubal Ligation	________
D&C (miscarriage)	__________
D&C (bleeding)	__________
Hysterectomy	__________
Myomectomy	__________
Uterine ablation	__________
LEEP/Cone biopsy	__________
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

STEADI 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.