ValleyCare Physicians Associates

Your name:_________________________________ Date of Birth:____/____/_____ Today's Date:____/____/_____

Reason for today's visit:____

Date of your last menstrual period_____________ What age did you have your first period?_______

Have you had a hysterectomy? □ No □ Yes If yes, what year?____________

Are you post-menopausal □ No □ Yes If yes, at what age?_________

What is your current method of birth control: □Pill □Patch □Nuvaring □IUD □Condoms Other_______

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

Date of your last Pap Smear______________ Mammogram (40+)_______________

Colonoscopy (50+)______________ Dexa/bone scan (65+)_____________

Do you smoke cigarettes □ No □ Yes If yes,________amt/day for how long?___________

Do you drink alcohol □ No □ Yes If yes, __________amt/day

Have you been a victim of abuse or domestic abuse? □ No □ Yes

If you have firearms in your home, are they locked up? □ Not Applicable □ No □ Yes

How many times have you been pregnant?________ How many children do you have?_________

How many were _____vaginal ______cesarean sections ______miscarriages _____abortions

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

Please list any Previous Hospitalizations, Surgery or Serious Injury.

Illness or Operation	Year	Illness or Operation	Year

Preferred Pharmacy ☐ **Mail Order**

Name: ____________________ Address: ______________________________ City: _______________

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Your name:________________________________ Date of Birth:____/____/_____ Today's Date:____/____/_____

Your Past or Present Illness	Yes	No
No known medical problems □		
Abnormal Pap smear		
Anemia		
Autoimmune disorder		
Bladder infections		
Blood transfusions		
Breast cancer		
Deep Vein Thrombosis/BloodClot		
Diabetes Type:______		
Endometriosis		
Fibroid uterus		
Heart disease or murmur		
Hepatitis		
High blood pressure		
Migraine headaches		
Ovarian cancer		
Pulmonary embolus		
Recurrent UTI		
Respiratory problems/Asthma		
Thyroid Disease		
Uncontrolled loss of urine		
Uterine cancer		
Other:		

Family history of	Relationship
No known medical problems □	
Alcoholism	
Autoimmune disorder	
Birth defects/ hereditary disease	
Bleeding problems	
Breast cancer	
Cervical cancer	
Colon cancer	
Congenital heart disease	
Coronary artery disease	
Cystic fibrosis	
Depression	
Diabetes	
Down's syndrome	
Genital cancer	
Heart disease	
High blood pressure	
Osteoporosis	
Ovarian cancer	
Thyroid disease	
Other:	
Other:	

Please list any prescribed medications you are currently taking: **□ None**

Name	Dose	Name	Dose

Please list any non-prescribed/over the counter medications you are currently taking: □ None

Name	Name

Please list any drug allergies you have: **□ None**

Name	Reaction	Name	Reaction