**********OFFICE USE ONLY**********

Chief Complaint:_____

HPI:_____

Ht:_____ Wt:_____ BP:_____ Pharmacy:_____

PLEASE TAKE A MOMENT TO FILL OUT THE FOLLOWING QUESTIONNAIRE:

DATE:_____NAME:_____DOB:_____

List any previous surgeries & date :_____

MEDICATIONS:_____

ALLERGIES:_____

PAST MEDICAL HISTORY

(check all that apply)

- o Anemia
- o Arthritis
- o Asthma/shortness of breath
- o Blood Clots/DVT
- o Blood Diseases
- o Breast Cancer
- o Breast problem(rash, pain, discharge, or lump)
- o Cancer
- o Constipation
- o COPD
- o Depression/Anxiety
- o Diabetes
- o Ear or hearing problems
- o Endometriosis
- o Eye/Vision problems
- o GI/Stomach problem (loss of appetite, change in bowl movements, blood in stool, abdominal pain)
- o Head Injury/Concussion
- o Headaches/Migraines
- o Heart Disease
- o Hepatitis
- o High Cholesterol
- o Hypertension
- o Infertility
- o Kidney/ Bladder problems(frequency, painful or burning urination, blood in urine, or leakage)
- o Liver disease
- o Lung disease
- o Muscle, joint or bone problems
- o Osteoporosis
- o Ovarian Cancer
- o Pulmonary Embolism
- o Reflux/GERD
- o Seizures/Epilepsy
- o Skin problems
- o Stroke
- o Thyroid Problems

List any other health problems:_____

SOCIAL HISTORY(do you?)

Smoke	Y N
Exercise	Y N
Diet	Y N
Alcohol	Y N
Illicit drugs	Y N
Perform monthly breast exams	Y N

FAMILY HISTORY (relation to you)

Hypertension _____

Diabetes _____

Breast cancer _____

Colon cancer _____

Ovarian cancer _____

Osteoporosis _____

GYN HISTORY

Vaginal discharge Y/ N

Sexual difficulty Y/N

History of sexually transmitted diseases Y/N

Painful or irregular periods Y/N

History of abnormal pap smears Y/N

Over the past 2 weeks have you felt down, depressed or hopeless? Y/N

Over the past 2 weeks have you felt little interest or pleasure in doing things? Y/N

Last Menstrual Period_____

Age at delivery of 1st child_____

Age at first menses_____

Current contraception_____

# of pregnancies/# of children____/____

Date of last Mammogram_____

Date of last Colonoscopy_____

Date of last Bone Density_____

Date of last pap smear_____