Name:____DOB:____________________Date:___________________

Occupation:__________________________________Marital Status: Single Married Divorced Separated

Reason for today's visit: Annual Problem____

Preferred Pharmacy:______________________

Allergies:____

Medications:

Name of Medication	Dosage	How Often	Reason you are taking the Medication
_________________	______	________	_______________________________
_________________	______	________	_______________________________
_________________	______	________	_______________________________
_________________	______	________	_______________________________
_________________	______	________	_______________________________
_________________	______	________	_______________________________
_________________	______	________	_______________________________

1st Day of Last Menstrual Period:__________ Date of Menopause:__________Age you started having periods:_______

Any problems with your cycles? Irregular Heavy Bleeding Pain Bleeding between periods Prolonged Bleeding

Date of Hysterectomy:_____________Type: Vaginal **OR** Abdominal Ovaries/Tubes: Removed Not Removed

Last Physical Exam:_________________ Last Pap Smear:__________Any Abnormal? Yes No
Last Mammogram:__________Any Abnormal? Yes No Last Colonscopy:__________Any Abnormal? Yes No

Current Birth Control: None Pills Condoms Patch Ring IUD Depo Provera Tubal Ligation Other______________

How often do you perform Self Breast Exams? Monthly Occasionally Rarely Never

Are you happy with your current Birth Control? Yes No Not using Birth Control
Are you happy with your current Hormone Replacement? Yes No Not using Hormone Replacement

Current Medical Problems:____

Past Medical Problems:____

Primary Physician:____________________Other physicians:____

____

Number of Pregnancies:_______Number of births:_______Number of Miscarriages:______Number of Abortions:______

Deliveries: Date:__________ Vaginal or C-Section M or F Birth Weight____pounds ____ounces_____

Date:__________ Vaginal or C-Section M or F Birth Weight____pounds ____ounces_____

Date:__________ Vaginal or C-Section M or F Birth Weight____pounds ____ounces_____

Date:__________ Vaginal or C-Section M or F Birth Weight____pounds ____ounces_____

Any problems during pregnancy?_________________________During Labor/Delivery?___________________________

Surgeries: Date:__________ Type:__________________ Date:___________Type:__________________

Date:__________ Type:__________________ Date:___________Type:__________________

Date:__________ Type:__________________ Date:___________Type:__________________

Family History: Mother: Alive Deceased Health Problems:____

Father: Alive Deceased Health Problems:____

Maternal Grandmother: Alive Deceased Health Problems:_____________________________

Maternal Grandfather: Alive Deceased Health Problems:_____________________________

Paternal Grandmother: Alive Deceased Health Problems: _____________________________

Paternal Grandfather: Alive Deceased Health Problems:_____________________________

Do you Smoke? Yes No If yes, do you smoke: Cigarettes Cigars Other_________________________

How much do you smoke in a day? 1-5 5-10 11-15 16-20 1 ½ packs 2 packs 3 packs

How long have you smoked?______________ Have you ever tried to quit? Yes No

Do you drink alcohol? Yes No If yes, type of alcohol: Wine Beer Other_______________________________

How often do you drink? Every Day Weekly Socially Rarely

Do you have any history of substance abuse? Yes No If yes, type of substance:______________________

Do you have any history of mental health issues? Yes No If yes, type of issue:___________________________

Do you have any history of communicable disease? Yes No If yes, type of disease:_________________________

****

I understand that if I am being seen for an annual exam and a problem is found that requires additional time or a procedure, I may have additional financial responsibility.

Signature____