

Patient History (part 1)

NAME: _____

Today's Date: ___/___/___

Date of Birth: ___/___/___

S E M Sep D W

My age today: _____yrs

Please List, AS THOUROUGHLY AS POSSIBLE,

ONGOING, CHRONIC MEDICAL PROBLEMS YOU ARE BEING TREATED FOR:

- 1.
- 2.
- 3.
- 4.
- 5.

WHICH PHARMACY WOULD YOU LIKE US TO ELECTRONICALLY SEND YOUR PRESCRIPTIONS TO?

_____ PHARMACY on _____ (street) IN _____ (city)

WHICH MAIL ORDER PHARMACY (if any) DO YOU USE? _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING DOSAGES AND FREQUENCY:

1. _____	DOSE: _____	FREQUENCY: _____
2. _____	DOSE: _____	FREQUENCY: _____
3. _____	DOSE: _____	FREQUENCY: _____
4. _____	DOSE: _____	FREQUENCY: _____
5. _____	DOSE: _____	FREQUENCY: _____
6. _____	DOSE: _____	FREQUENCY: _____

HAVE YOU LISTED ALL OF THE MEDICATIONS YOU ARE CURRENTLY TAKING, WITH DOSE/FREQUENCY? YES NO

ALLERGIES:

List all allergies you have to medications with reactions:

Are you LATEX Allergic Sensitive

1. _____	Reaction: _____
2. _____	Reaction: _____
3. _____	Reaction: _____
4. _____	Reaction: _____

Have you listed all of your allergies?? YES NO

Brief Gynecologic History:

WHAT FORM OF CONTRACEPTION ARE YOU CURRENTLY USING (IF ANY)??? _____

Age when periods began: _____. Age when they stopped (if in menopause) ____

Have you ever been pregnant? Yes No

How many times pregnant? _____ Number of: Full Term _____ Premature _____

Dates of pregnancies: _____ Miscarriages _____ Stillbirths _____

How old are your children? _____ Ectopic preg. _____ Abortions _____

Patient History (part 2)

PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE

LIST ALL SURGERIES YOU HAVE HAD WITH DATES (month/year)

1. _____
2. _____
3. _____

4. _____
5. _____
6. _____

Past Medical History: Have you ever had?

- Abnormal PAP Smear
- Asthma or other lung disease
- Breast lumps / nipple discharge
- Chronic urinary tract infections
- Depression, anorexia, bulimia
- Diabetes
- DVT or phlebitis
- Elevated cholesterol
- Endometriosis
- Genital warts / HPV / Condyloma / Herpes / PID
- Gonorrhea / Chlamydia / Trichomonas
- Heart disease
- Hepatitis A, B, or C
- High blood pressure
- Kidney or bladder disease
- Liver or gallbladder disease
- Migraines or other type of headache
- Mitral valve prolapse
- Pathologic ovarian cysts
- Psychiatric disorder
- Seizures or other neurologic disorder
- Sickle cell, thalassemia
- Stroke
- Thyroid disorder
- Uterine fibroids
- Vision or hearing problems
- ANY OTHER UNUSUAL HISTORY????
- _____

Family History: Please include specifically which family member (and on which side, your mother or father) and the age at which they had the disease?

- Breast cancer _____
- Ovarian cancer _____
- Cervical / uterine cancer _____
- Colon cancer _____
- Osteoporosis _____
- Diabetes _____
- Hypertension _____
- Heart disease _____
- Stroke _____
- Sickle cell / Thalassemia _____
- Tay Sachs _____
- Inheritable genetic disorder _____

Social History:

Do you smoke? Yes No former
cigarettes / day: _____

Do you drink? Yes No

#drinks / day: _____ #drinks / week: _____

Do you think you drink too much? Yes No Maybe

Do you now or have you had an eating disorder? Yes No

Exercise (Type / Duration / Frequency):

Gynecologic / Obstetric History:

IF APPLICABLE:

Period comes every _____ days and lasts _____ days Has there been a change in your periods recently? Yes No

Painful periods? None Mild Moderate Severe Incapacitating Medications used: _____

Do you have PMS? None Mild Moderate Severe

What are your symptoms? _____ How do you treat them? _____

Are you currently sexually active? Yes No Number of sexual partners in the last year: _____ last 5 years: _____

Do you have pain with intercourse? Yes No

Date of your last pelvic / PAP exam: ____/____/____

Date of your last Mammogram ____/____/____

Date of your last DEXA scan: ____/____/____

Date of your last Colonoscopy: ____/____/____