Patient Name: _____DOB:_____

Date of Visit: _____ Purpose of Visit: _____

_____

Past Medical History:

Are you being treated for any medical conditions? If YES please list:

Condition	How Long

Medications:

Medication	How Many Times a Day	How Long

Allergies:

Are you allergic to any medication or food substance? If YES please list:

Allergic to	Reaction

Screening Tests:

Please list dates of most recent screening:

Test	Date
Lipids	
Stool Test for Occult Blood	
Colonoscopy	
Mammogram	
Pap Smear	
Bone Density	

Past Pregnancies:

Number of times pregnant: ________ Number of living children: ________ Number of miscarriages: ________

List Date	Circle One	If Delivery, Circle One
	Delivery / Miscarriage	C-Section / Vaginal Delivery
	Delivery / Miscarriage	C-Section / Vaginal Delivery
	Delivery / Miscarriage	C-Section / Vaginal Delivery
	Delivery / Miscarriage	C-Section / Vaginal Delivery
	Delivery / Miscarriage	C-Section / Vaginal Delivery
	Delivery / Miscarriage	C-Section / Vaginal Delivery
	Delivery / Miscarriage	C-Section / Vaginal Delivery
	Delivery / Miscarriage	C-Section / Vaginal Delivery
	Delivery / Miscarriage	C-Section / Vaginal Delivery
	Delivery / Miscarriage	C-Section / Vaginal Delivery

Problems:
Circle all that apply:

Breast Lumps / Vaginal Bleeding / Vaginal Discharge / Hot Flashes / Cramps

Irregular Periods / Menopause / Painful intercourse / Night Sweats

Family History:
Has any blood relative ever had any of the following illnesses? Circle all that apply:

Cancer / Heart Disease / Hypertension / Glaucoma / Diabetes / Attempted or Committed Suicide

Emotional – Nervous – Mental Breakdown

Please answer the following about your relationship to each person and the problem:

Relationship	Age if Living	Medical Problem	Cause of Death	Age at Death