Name: _____D.O.B._____ DATE: _____

CURRENT PROBLEMS (please check all that apply)

GENERAL
- o FEVER
- o CHILLS
- o WEIGHT GAIN
- o WEIGHT LOSS
- o FATIGUE
- o LOSS OF APPETITE
- o HOT FLASHES

EYES
- o VISUAL DISTURBANCES
- o DRY EYES
- o GLAUCOMA

EARS, NOSE, THROAT
- o SORE THROAT
- o SINUS PROBLEMS
- o FREQUENT COLDS
- o HEADACHES

BREASTS
- o LUMPS
- o TENDERNESS / PAIN
- o SWELLING
- o NIPPLE DISCHARGE

RESPIRATORY
- o SHORTNESS OF BREATH
- o WHEEZING
- o CHRONIC COUGH

CARDIOVASCULAR
- o CHEST PAIN
- o CARDIAC PALPATATIONS
- o IRREGULAR HEARTBEATS
- o SWELLING OF LEGS
- o VARICOSITIES

GASTROINTESTINAL
- o DIARRHEA
- o CONSTIPATION
- o HEARTBURN
- o VOMITTING BLOOD
- o NAUSEA / VOMITTING
- o BLOOD IN STOOLS

GENITOURINARY
- o LEAKING URINE
- o PAIN WITH URINATION
- o FREQUENT URINATION
- o VAGINAL DISCHARGE
- o VAGINAL DRYNESS
- o ABNORMAL PAP SMEAR
- o UTERINE TUMOR
- o UNUSUAL BLEEDING
- o OVARY PROBLEMS
- o PAINFUL INTERCOURSE
- o DECREASED LIBIDO

SKIN
- o RASH
- o ITCHING
- o NEW SKIN LESIONS
- o NEW LUMPS / LESIONS
- o EXCESSIVE BODY HAIR

MUSCULOSKELETAL
- o JOINT PAIN
- o BACK PAIN
- o MUSCLE WEAKNESS
- o MUSCLE CRAMPS

ENDOCRINE
- o EXCESSIVE THIRST
- o HEAT INTOLERANCE
- o DIFFICULTY STAYING WARM
- o HAIR LOSS

EMOTIONAL
- o DEPRESSION
- o ANXIETY
- o EMOTIONAL CHANGES
- o DIFFICULTY SLEEPING
- o MOOD SWINGS

HEMATOLOGIC
- o EASY BRUISING
- o EASY BLEEDING

MEDICAL HISTORY (please check all that apply)

PERSIONAL HISTORY & FAMILY HISTORY

- o **Abuse/Domestic Violence**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

- o **Anemia**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

- o **Asthma**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANFDATHER	o **OTHER** _____

- o **Birth defects or inherited diseases**

o SELF

o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Bleeding tendencies**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Breast cancer**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Cancer**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Cervical cancer**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Colon cancer**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Cystic fibrosis**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **DVT (deep vein thrombosis)**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Depression**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	

o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Diabetes**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Endometrial cancer**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Heart disease**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Hepatitis**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **High cholesterol**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Kidney disease**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Hypertension**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Infertility**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT.	o MAT.	o PAT.	o PAT.	o **OTHER**

GRANDMOTHER	GRANDFATHER	GRANDMOTHER	GRANDFATHER	_____

- **Kidney disease**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

- **Lung cancer**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

- **Osteoporosis**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

- **Ovarian cancer**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

- **Parkinson's disease**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

- **Pre-eclampsia**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

- **Psychiatric illness**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

- **Sickle cell trait**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHE	o MAT. GRANDFATHE	o PAT. GRANDMOTHE	o PAT. GRANDFATHER	o **OTHER** _____

R	R	R		

o **Stroke**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Thyroid problems**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Uterine cancer**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Varicosities**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

o **Other: (if checked, please list): _____**

o SELF				
o MOTHER	o FATHER	o SISTER	o BROTHER	
o MAT. GRANDMOTHER	o MAT. GRANDFATHER	o PAT. GRANDMOTHER	o PAT. GRANDFATHER	o **OTHER** _____

Please continue to next page……..

MEDICAL ALLERGIES

(Medications, seasonal, Latex, Vitamins, Herbs)	Reaction(s)

MEDICATIONS (Over the counter, Prescriptions, Vitamins, Herbs)

Drug Name	Dosage	How Often	Reason(s)

SURGICAL HISTORY

Name of Surgery	MM/YY	Reason(s)

GYN HISTORY

First date of last menstrual period:_____ Number of weeks between periods:_____

Flow period (circle one): LIGHT MODERATE HEAVY Are your periods regular: (YES / NO)

Days your periods last:_____ Do you SPOT in between periods: (YES / NO)

Post-Menopausal Bleeding: (YES / NO) Age of first period: _____ Post-Menopausal: (YES / NO)

Currently Sexually active: (YES / NO) Sexual Problems: (Y/N) if yes, explain:_____

Bleeding after intercourse: (YES / NO) Number of sexual partners:_____

History of STD's/STI's: (Y/N) if yes, explain:_____

HPV Vaccine: (YES /NO) Hormone Replacement therapy: (YES / NO) Protected sex: (YES / NO)

Current birth control method:_____ Desired Birth Control:_____

Date of last PAP Smear:_____

History of abnormal PAP: (YES / NO) if yes, when:_____

Date of last Mammogram (over the age of 40 yrs.):_____

History of abnormal Mammogram: (YES / NO) if yes, when:_____

Date of bone density scan (over the age of 65 yrs.):_____

Date of last colonoscopy:_____ Do you perform monthly self-breast exams: (YES / NO)

PREGNANCY HISTORY

Age at first Child:_____ Total pregnancies:_____ Number of live births:_____

Number of miscarriages:_____ Date of miscarriage(s):_____

Number of abortions:_____ Date of abortion(s):_____

Birth DATE	Weeks of gestation	sex	weight	type of delivery	complications

SOCIAL HISTORY

- **Tobacco use (chew/smoke): (YES / NO) if yes, amount:_____ Years of use:_____**
- **Alcohol use (circle one): NONE OCCASIONAL MODERATE HEAVY Amount:_____**
- **Marital status:_____**
- **Diet (circle one): REGULAR / GLUTEN-FREE/ VEGETARIAN/ VEGAN/ CARDIAC/ CARBOHYDRATES/ DIABETIC**
- **Caffeine intake: NONE OCCASIONAL MODERATE HEAVY**
- **Currently employed: (YES / NO)**
  Employer:_____
- **Drug use: (YES / NO) if yes, what type:_____ Years of use:_____**
- **Education (circle one):**
  Less than 8th grade (9, 10, 11, 12) HIGH SCHOOL DIPLOMA, 2 Year College, 4 Year College, <4 year College
- **Changes in home/family situation: (YES / NO)**
- **Is blood transfusion acceptable in a medical emergency? (YES / NO)**
- **Medical Power of Attorney: (YES / NO)**
- **TB Risk? (circle one): (LOW / HIGH)**
- **HIV risk factor? (YES / NO)**
- **Smokers in the home? (YES / NO)**
- **Exposure to Chemicals or Toxins in the home or work place: (YES / NO)**
- **Exposure to animals: (YES / NO)**
- **Exposure to cat litter: (YES / NO)**

Emergency contact/Relationship: **Contact Phone number:**