



Patient Name _____

Date _____

How did you hear about us? (check one): Primary Care Physician Specialist Physician Family Member
 Friend Insurance Directory Internet Yellow Pages Other (please specify) _____

Name of Spouse Guardian Partner (choose one): _____

Reason for your visit today: _____

Personal History:

Do you have	Yes	No	Do you have	Yes	No
Asthma			Anemia		
Arthritis			History of blood clots		
Depression			Cancer		
Heart Disease			Seizures		
Kidney Disease			Personal history of breast disease/cancer		
History of Stroke			History of Rheumatic Fever		
Ulcers			Thyroid Disease		
Mitral Valve Prolapse			Diabetes		
High Cholesterol			History of blood disorder		
History of Blood Transfusion			History of Tuberculosis		
Gallbladder Disorder			High Blood Pressure		
Vision/Hearing/Speech Disorder			Liver Disorder		
			History of reaction to general anesthesia		

Other Conditions: _____

Allergies to Medications:

1. _____ 2. _____ 3. _____ 4. _____
 5. _____ 6. _____ 7. _____ 8. _____

Medications/Supplements/Vitamins (Please list with dosage):

Menstrual History:

Date of last menstrual period _____
 Age menses began _____
 Age of menopause _____
 Cycles typically occur every _____ days
 Cycles typically last _____ days
 Cycles are typically light moderate heavy
 Are your cycles painful Yes No
 Are you sexually active Yes No

Preventative:

Have you had: Yes No Date
 Mammogram _____
 Pap Smear _____
 Colonoscopy _____
 Bone Density Test _____
 Cholesterol Screen _____
 Thyroid Screen _____
 Sugar Screen _____

