Patient Name: _____ Date of Birth: _____ Date : _____

wt: _____ HP: _____

OBSTETRICAL/GYNECOLOGICAL HISTORY:

Age at menses: _____ Last menstrual period: _____ # of pregnancies: _____

# of miscarriages/abortions_____

Age at first live birth : _____ Number of Children: _____ Breast feeding history: ▫Yes ▫No Age at menopause _____

Birth Control Pill:

▫ Yes Number of years taken _____ ▫ Never

▫ Previously taken How many years taken _____ No. of years since last taken _____

Hormone Replacement :

▫ Yes Number of years taken _____ ▫ Never

▫ Previously taken How many years taken _____ No. of years since last taken _____

SOCIAL HISTORY:

Marital Status ▫ Single ▫ Married ▫ Widowed ▫ Divorced

Alcohol ▫ Denies ▫ Current: _____drinks per day/ week/ month

Tobacco ▫ Denies ▫ Current: _____ packs/day ▫Past _____ packs/day Year Quit _____

Illicit Drugs ▫ Denies ▫ Current Substances: _____ ▫ Past Substances _____

Caffeine: ▫ Denies Cups/Day _____

REVIEW OF SYSTEMS: Have you recently had any of the following: (please check (√) if yes)

General: ▫Weight loss (how much) _____ ▫Weight Gain (how much)_____

Skin: ▫ Skin Problems ▫ Skin Lesions ▫Psoriasis

HEENT: ▫ Visual Problems ▫ Hearing Problems ▫ Nose/Throat Infections ▫Sore throat

Pulmonary: ▫ Shortness of breath ▫ chronic cough▫ Other _____

Cardiovascular: ▫ Irregular Heartbeat/Arrhythmia ▫ History of Heart Attack ▫ Past Cardiac Surgery

Peripheral Vascular: ▫ History of leg cramping with walking

Gastrointestinal: ▫ Acid Reflux ▫ Abdominal Pain ▫ change in bowel habits ▫ blood in stool

Genitourinary: ▫ History of blood in urine ▫ Incontinence

Endocrine: ▫ History of thyroid problems ▫ Diabetes ▫ Other _____

Hematology/Immune: ▫ Anemia ▫ Bleeding Problems ▫ Auto Immune Disorders

Musculoskeletal: ▫ Chronic Back Pain ▫ Neck Pain ▫Other _____

Neurological/Psych: ▫ Depression ▫ Anxiety ▫ Neurological Disorder _____