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PATIENT NAME: ____
BIRTH DATE: ___/___/____ AGE: _____
VISIT DATE: ___/___/____

PHYSICAIN HISTORY

NEW PATIENT ____ ESTABLISHED PATIENT ____

PRIMARY CARE PHYSICIAN: ______________________ OTHER PHYSICIANS: ______________________

CHIEF COMPLAINT: _____________________________ HISTORY OF PRESENT ILLNESS: _____________________________

CURRENT PRESCRIPTION MEDICATIONS:
1.) ___________________ 2.) ___________________
3.) ___________________ 4.) ___________________

CURRENT NON-PRESCRIPTION MEDICATIONS:
1.) ___________________ 2.) ___________________
3.) ___________________ 4.) ___________________

ALLERGIES (DESCRIBE REACTION): ____NONE
1.) ___________________ REACTION___________________
2.) ___________________ REACTION___________________

LAST CERVICAL CANCER SCREENING (PAP SMEAR) ____/____/____ HPV SCREENING ____/____/____

LAST MAMMOGRAM ____/____/____ LAST COLORECTAL SCREENING ____/____/____

GYNECOLOGIC HISTORY (PH)

LMP: ____/____/____ AGE AT MENARCHE: ________ LENGTH OF FLOW: _____to_____ days

INTERVAL BETWEEN PERIODS: ____/DAYS RECENT CHANGES: _____________________________

CURRENT METHOD OF CONTRACEPTION: ________________________ PAST CONTRACEPTIVE HISTORY: ________________________

OBSTETRIC HISTORY (PH)

PREGNANCIES NUMBER: _____ ABORTIONS NUMBER: _____ MISCARRIAGES NUMBER: _____ STILL BIRTHS NUMBER: _____

PREMATURE BIRTHS (<37 WEEKS AND BELOW): _____ LIVE BIRTHS NUMBER: _____ LIVING CHILDREN NUMBER: _____

LIST LIVE/STILL BIRTHS WITH INFORMATION:

1ST CHILD: BIRTH DATE: ____/____/____ WEIGHT AT BIRTH: _____ BABY'S SEX: _____ WEEK'S OF PREGNANCY: _____

TYPE OF DELIVERY: _____VAGINAL _____CESAREAN

2ND CHILD: BIRTH DATE: ____/____/____ WEIGHT AT BIRTH: _____ BABY'S SEX: _____ WEEK'S OF PREGNANCY: _____

TYPE OF DELIVERY: _____VAGINAL _____CESAREAN

3rd CHILD: BIRTH DATE: ____/____/____ WEIGHT AT BIRTH: _____ BABY'S SEX: _____ WEEK'S OF PREGNANCY: _____

TYPE OF DELIVERY: _____VAGINAL _____CESAREAN

ANY PREGNANY COMPLICATIONS? _____DIABETES _____HYPERTENSION/HIGH BLOOD PRESSURE _____PRECLAMPSIA/TOXEMIA ______OTHER

ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? _____NO _____YES, HOW WAS IT TREATED? ___________________

PAST HISTORY (PH)

_____NON-CONTRIBUTORY _____ NO INTERVAL CHANGES SINCE ____/____/____ SURGERIES: ____

ILLNESSES (PHYSICAL AND MENTAL): ________________________ INJURIES: ________________________

IMMUNIZATIONS/TUBERCULOSIS TEST: ________________________

PHYSICIAN HISTORY
(Continued)

VISIT DATE: ___/___/____

PATIENT NAME: ____ **BIRTH DATE:** ___/___/____

FAMILY HISTORY (FH)

___NONCONTRIBUTORY ___NO CHANGE SINCE ___/___/____

MOTHER ____LIVING _____DECEASED-CAUSE: ______________ AGE AT TIME OF DEATH: _____
FATHER ____LIVING _____DECEASED-CAUSE: ______________ AGE AT TIME OF DEATH: _____

SIBLINGS NUMBER **LIVING:** _____ NUMBER **DECEASED:** _____

DECEASED-CAUSE: ______________AGE AT TIME OF DEATH: _____
DECEASED-CAUSE: ______________AGE AT TIME OF DEATH: _____
DECEASED-CAUSE: ______________AGE AT TIME OF DEATH: _____

CHILDREN NUMBER **LIVING:** ______ NUMBER **DECEASED:** _____

DECEASED-CAUSE: ______________AGE AT TIME OF DEATH: _____
DECEASED-CAUSE: ______________AGE AT TIME OF DEATH: _____

FAMILY CONDITIONS HISTORY
(CHECK ALL THAT APPLY)

_____**DIABETES** WHOM: __________ AGE AT DIAGNOSIS: _____

_____**CANCER** WHOM: __________ AGE AT DIAGNOSIS: _____

_____**HEART DISEASE** WHOM: __________ AGE AT DIAGNOSIS: _____

_____**OSTEOPOROSIS** WHOM: __________ AGE AT DIAGNOSIS: _____

_____**HYPERTENSION** WHOM: __________ AGE AT DIAGNOSIS: _____

_____**HYPERLIPIDEMIA** WHOM: __________ AGE AT DIAGNOSIS: ____

_____**DEEP VENOUS THROMBOEMBOLISM/PULMONARY EMBOLISM** WHOM: __________ AGE AT DIAGNOSIS: ____

SOCIAL HISTORY (SH)
(MARK EACH ONE YES OR NO)

___NONCONTRIBUTORY ___NO CHANGE SINCE ___/___/____

TABACCO USE _____YES _____ NO AMOUNT PER DAY: _____

ILLEGAL/STREET DRUGS USE _____YES _____ NO

ALCOHOL USE _____YES _____ NO AMOUNT: __________ KIND: _______

MISUSE OF PRESCRIPTION DRUGS _____YES _____ NO

INTIMATE PARTER VIOLENCE_____YES _____ NO

SEXUAL ABUSE _____YES _____ NO

HEALTH HAZARDS AT WORK/HOME _____YES _____ NO

DO YOU WEAR A SEATBELT _____YES _____ NO

DO YOU TAKE FOLIC ACID _____YES _____ NO **DO YOU TAKE CALCIUM** _____YES _____ NO **DO YOU DINK CAFFEINE** _____YES _____ NO

DO YOU EXERCISE REGULARLY _____YES _____ NO **IS THERE ANYTHING WE SHOULD DISCUSS ABOUT YOUR DIET** _____YES _____ NO

DO YOU HAVE AN ADVANCED DIERECTIVE OR LIVING WILL _____YES _____ NO **ARE YOU AN ORGAN DONOR** _____YES _____ NO

PERSONAL HISTORY
(JUST HELPS THE DOCTOR TO KNOW YOU BETTER)

EMPLOYER/SCHOOL: ________________________________**OCCUPATION/STUDENT:** ________________________________

FULL-TIME/PART-TIME: ________________________________ **HOW LONG:** ____________________

SPOUSE NAME: ______________________________________

EMPLOYER/SCHOOL ________________________________**OCCUPATION/STUDENT**________________________________

FULL-TIME/PART-TIME________________________________ **HOW LONG** ____________________

WHOM MAY WE THANK FOR YOUR REFERRAL?: ____