Medical History **Name**_____ **Age** _____

What is the reason for your visit today?_____
Do you have any particular health concerns?_____

Are you allergic to any medications? ☐ No ☐ Yes. If yes please list below with noted reaction.
_____ ☐ rash or hives ☐ swelling of lips or tongue ☐ anaphylaxis
_____ ☐ rash or hives ☐ swelling of lips or tongue ☐ anaphylaxis
_____ ☐ rash or hives ☐ swelling of lips or tongue ☐ anaphylaxis
Are you allergic to latex? ☐ No ☐ Yes

List any prescription medications you take on a regular basis.

_____	_____	_____
_____	_____	_____
_____	_____	_____

How many total times have you been pregnant?_____ **How many live births?**_____
Have you had any miscarriages? ☐ **No** ☐ **Yes** Have you had any abortions? ☐ **No** ☐ **Yes**
If you have children, were they delivered by ☐ vaginal birth ☐ cesarean delivery ☐ both

When was the 1st day of your last period?_____ **At what age did you have your first period?**_____
My period comes every ☐ **28 days** ☐ **<28** ☐ **29-35** ☐ **>35 days** and lasts for ☐ **< 3 days** ☐ **4-7** ☐ **>7 days**
My periods are ☐ light ☐ moderate ☐ heavy ☐ heavy with clots ☐ bleeding in between my periods

If in menopause, what year? _____ Do or did you ever take hormone replacement? ☐ **No** ☐ **Yes**
Are you having ☐ hot flashes ☐ irritability ☐ vaginal dryness ☐ painful intercourse ☐ difficulty sleeping

When was your last Pap smear? _____**What was the result?**_____
Have you received Gardasil (the HPV vaccine)? ☐ **No** ☐ **Yes** If no, would you like more information today? ☐ **No** ☐ **Yes**
Have you ever had an abnormal Pap smear? ☐ **No** ☐ **Yes**
If yes, how was it managed? ☐ observation ☐ colposcopy ☐ LEEP ☐ cryosurgery ☐ laser ☐ hysterectomy

Are you currently sexually active? ☐ **No** ☐ **Yes** If no, have you ever been sexually active? ☐ **No** ☐ **Yes**
If you are currently sexually active are you planning pregnancy? ☐ **No** ☐ **Yes**
If no, which of the following methods are you using to prevent pregnancy? ☐ **None**
☐ condoms ☐ pills/Nuvaring ☐ depo-provera ☐ Nexplanon ☐ Mirena/Skyla ☐ Paragard ☐ vasectomy ☐ tubal ligation/Essure
Are you interested in a **new** form of birth control? ☐ **No** ☐ **Yes**
Are you interested in a **permanent** form birth control? ☐ **No** ☐ **Yes**

Have you ever been diagnosed with/treated for a sexually transmitted infection? ☐ No ☐ Yes
If yes, ☐ gonorrhea ☐ chlamydia ☐ herpes ☐ trichomonas ☐ HPV ☐ hepatitis ☐ syphilis ☐ HIV

Do you have any of the following **gynecologic conditions**? ☐ **None**
☐ fibroid uterus ☐ recurrent ovarian cysts ☐ endometriosis ☐ recurrent vaginal infections ☐ infertility
☐ painful periods ☐ sexual dysfunction ☐ painful intercourse ☐ premenstrual syndrome ☐ pelvic pain

Do you have any of the following **urologic symptoms**? ☐ **None**
☐ painful urination ☐ frequency ☐ urgency ☐ incomplete emptying ☐ blood in urine ☐ loss of urine
☐ urinate 2 or more times overnight ☐ recurrent urinary tract infections ☐ history of kidney infections

List any **medical conditions** for which you are currently under a doctor's care.

_____	_____	_____
_____	_____	_____
_____	_____	_____

List any **surgeries**, procedures, or hospitalizations.

Date	**Surgical procedure or reason for hospitalization**
_____	_____
_____	_____
_____	_____

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What medical conditions run in your **family**? Your family history predicts your future health!
For each family member below, **please indicate ☑ A, if alive or ☑ D, if deceased and at what age**. If unknown, leave blank. Blank lines at bottom are for additional family members. Then along the line, list known medical conditions for that family member. ***Consider the following***: *heart disease, high blood pressure, high cholesterol, diabetes, stroke, asthma, osteoporosis, Alzheimer's disease, cancers such as breast, ovary, uterus, colon, prostate, pancreas, stomach, melanoma, etc.*

Mother ☐ A ☐ D (age____) _____
Father ☐ A ☐ D (age____) _____
Sister ☐ A ☐ D (age____) _____
Sister ☐ A ☐ D (age____) _____
Brother ☐ A ☐ D (age____) _____
Brother ☐ A ☐ D (age____) _____
Daughter ☐ A ☐ D (age____) _____
Daughter ☐ A ☐ D (age____) _____
Son ☐ A ☐ D (age____) _____
Son ☐ A ☐ D (age____) _____
Maternal aunt ☐ A ☐ D (age____) _____
Maternal uncle ☐ A ☐ D (age____) _____
Paternal aunt ☐ A ☐ D (age____) _____
Paternal uncle ☐ A ☐ D (age____) _____
Maternal grandmother ☐ A ☐ D (age____) _____
Maternal grandfather ☐ A ☐ D (age____) _____
Paternal grandmother ☐ A ☐ D (age____) _____
Paternal grandfather ☐ A ☐ D (age____) _____
_____ ☐ A ☐ D (age____) _____
_____ ☐ A ☐ D (age____) _____

What is your **occupation**? _____ What is your **marital status**? _____
Who lives with you at home? _____
Have you ever been a victim of or threatened by sexual, physical or emotional abuse by your partner? ☐ **No** ☐ **Yes**

Do you take any vitamins, supplements or herbal remedies?
☐ none ☐ multi-vitamin ☐ Calcium ☐ Vitamin D ☐ Omega 3/fish oil ☐ B complex ☐ Vitamin C ☐ probiotic
List any other _____

Do you smoke cigarettes? ☐ never ☐ former smoker ☐ current smoker
If a **current smoker**, what year did you start? _____ Are your trying to quit ☐ **No** ☐ **Yes**
If a **former smoker**, what year did you start? _____ What year did you quit? _____
If a **former/current smoker**, how many packs? ☐ <1 pack per day ☐ 1 ppd ☐ 1-2 ppd ☐ >2 ppd

Do you drink alcohol? ☐ 0-12 drinks/year ☐ 1-13 drinks/month ☐ 4-14 drinks/week ☐ >2 drinks/day
Have you ever felt the need to cut down? ☐ **No** ☐ **Yes**
Have you been annoyed by others telling you to cut down? ☐ **No** ☐ **Yes**
Do you use recreational drugs? ☐ **No** ☐ **Yes** If yes, which one(s)_____
Have you ever been in rehabilitation for alcohol or drug abuse? ☐ **No** ☐ **Yes**
How much caffeine do you drink? ☐ none ☐ 1 cup/day ☐ 2 cups/day ☐ 3+ cups coffee, tea or cola/day

Do you exercise regularly? ☐ no ☐ occasionally ☐ once per week ☐ 2-3x/week ☐ 4-6x/week ☐ daily
What types of exercise? ☐ walking ☐ cardiovascular ☐ weight training ☐ yoga ☐ pilates ☐ _____

How tall are you? _____ Are you at your ideal weight? ☐ **No** ☐ **Yes**
If no, are you interested in our medically supervised weight loss & wellness program? ☐ **No** ☐ **Yes**

If applicable, when was your last?
Mammogram?_____**What was the result?** _____ **Where?** _____
Bone Density?_____**What was the result?** _____ **Where?** _____
Colonoscopy? _____**What was the result?** _____**Where?** _____

Email address _____ Best contact number_____
Name/location of your pharmacy_____ Pharmacy phone number_____

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