NAME_____ Date of birth_____ Date:_____

Primary Care Provider _____ **Preferred Pharmacy** _____

*Other Specialists*_____ ***Pharmacy location*** _____

OB History # Pregnancies_____ Full term_____ Premature____Miscarriage_____ Abortion_____

Ectopic____ Multiple _____ Living Children_____ *Death of Infant or Child*____

Year Delivered	Gestational Age	Vaginal/Cesarean	Newborn Weight	Complications

Add additional on back of page if needed

Health Screening

Last Pap_____

*Abnormal Paps*_____

Treatment _____

Last Mammogram_____.

Last Colonoscopy_____

Bone Density Scan (DEXA) _____

Married _____ Widowed_____ Single_____ In a Relationship_____ Not Sexually Active _____

*Are your sexual partner(s) ____ men ____ women ____ both men and women Would you like STD screening?*_____

Are you trying to Conceive? _____ **Method of CONTRACEPTION** _____

(including condoms, vasectomy and tubal ligation)

First day of LAST MENSTRUAL PERIOD_____ Menstrual Frequency_____ Duration_____

Heavy_____ Clots_____ Irregular_____ Painful_____ Skipping periods_____ Bleeding with sex_____ PMS_____

Vulvar-Vaginal problems *(discharge, odor, itching, rash/lesions, pain)*, _____

Pelvic Pain _____ Pain with sex _____

Urinary Problems *(pain, frequency/urgency, incontinence, blood in urine)* _____

Gastrointestinal Problems *(diarrhea/constipation, bloody stools, bloating, hemorrhoids*_____

Menopause issues *Hot Flash/Night Sweats*_____ *Post-Menopausal bleeding*_____ *Vaginal dryness*_____

Breast *(Lump or problem)* _____ **Other Concerns**_____

YOUR Medical History

____GYN disorders _____

_____

____Asthma

____Blood clots in legs or lungs

____Bladder / Kidney diseases

____Gastrointestinal Disease

____Cancer_____

____Cholesterol elevated

____Depression / Anxiety / Other

____ Diabetes

____ Hypertension

____Hypo / Hyper thyroid

____Osteopenia/Osteoporosis

____ Neurological Diseases / Seizures___

____ Sleep Apnea / CPAP? _____

____ Victim of Physical/Sexual assault

Other:_____

_____

Family History *which family member*

Diabetes_____

Heart Disease_____

Hypertension_____

Thyroid disorder_____

Osteoporosis _____

Clots in leg/lungs_____

Breast Cancer_____

Ovarian Cancer_____

Uterine Cancer_____

Colon Cancer_____

Other Cancer_____

Surgeries ***(since your last visit)***

_____

_____

_____

_____

_____

_____

_____

Do you use tobacco/nicotine?_____. Former smoker _____ year quit_____.

Alcohol frequency _____ Marijuana use_____ Drug use (cocaine, meth, heroin) _____

Exercise_____ Occupation _____

Write Medications and Allergies on the back of the page. >>>>>>>>>

Medications ***(drug name dose frequency.)***

Vitamins / Supplements.

Allergies to Medications	**What is the allergy reaction?**