

Although some of the information requested below may not seem pertinent, it helps us provide you with the best care. We ask that you fill out ALL of the following questions completely.

Date _____ Name _____ Birth Date _____ Age ____ Race/Ethnicity _____
Phone: Home _____ Work _____ Cell _____ Email _____
Preferred Pharmacy: Name _____ Address _____ Zip Code ____ Phone _____
Is there someone we can thank for referring you? _____ Primary Physician _____

Physician/Provider: Abikhaled Gooch Grogono Kish McCoin Nunnely Reue Hoverman Rowan PA Spring NP Palmer NP

REASON FOR YOUR VISIT TODAY: (details if necessary)

Date of last Annual Exam _____ Date of Last Pap Smear _____
Have Paps ever been Abnormal? _____ Did you receive any treatment? When? _____
Have you ever had a Mammogram? _____ Date/Results: _____
Have you ever had a Bone Density Scan? _____ Date/Results: _____
Have you ever had a Colonoscopy/flexsigmoidoscopy? Date/Results: _____
Have you ever had a Blood Transfusion? (List date/reason) _____
Would you accept blood or blood products in case of an emergency? _____ If not, please explain _____
Have you ever had Chicken Pox? _____
Have you ever had complications with Anesthesia of any kind? Please explain _____
Did your mother receive a drug called DES when she was pregnant with you? _____

Age at 1st period _____ How far apart are your cycles (ex.28days) _____ How many days do you bleed (i.e. 5days) _____
Menstrual flow (please circle): Light Medium Heavy Is menstrual pain or cramping a problem for you? YES NO
When was the FIRST day of your last period? _____ How certain are you: Very Somewhat Not at all
What is your current birth control method? (Please choose one):
Nothing... Condoms... Pills/Ring/Patch... IUD... Tubal... Vasectomy... Menopause... Hysterectomy... Other: _____
Do you desire a change to your current birth control method? _____
Are you Menopausal: N/A Yes No Age at Menopause: _____ Are you on hormones? Type? _____

REPRODUCTIVE HISTORY

Total # of pregnancies _____ Total # of live children _____ # of Abortions (list dates) _____
Miscarriages or Ectopics (list dates & how far along you were): _____

Table with 9 columns: Date of Delivery, # Weeks Pregnant, Hours in Labor, Birth Weight, Sex & Name, Delivery Type, Anesthesia Type, Location, Complications (i.e. preterm labor)

Please list any surgeries or hospitalizations you have undergone (D&C, Hysterectomy, Cesarean Section)
Year of Surgery Type / Reason for MD Hospital

SURGICAL HX

SOCIAL HISTORY

Marital Status (please check one):
 Single/Not Dating Married
 Single/ Dating Divorced
 In a committed relationship Widowed
 Engaged

PARTNER'S NAME: _____ **Age:** _____

Safety: Do you feel safe in your current relationship: Yes No
 If not please explain _____

Have you ever been physically abused in a relationship: Yes No
 If so, please explain _____

Have you ever had an unwanted sexual encounter: Yes No
 If so, please let us know when this occurred: _____

Substance Use: Do you drink alcohol: Yes No
 How many drinks per day or week: _____
 Do you currently use any illicit drugs: Yes No
 Type _____
 How often _____

Do you smoke cigarettes: Yes No Never Current Former
 How many per day _____
 How long have you been a smoker: _____

Occupation: _____

Do you Exercise: Yes No
 Type _____
 How often _____

Infection Risk:
 Are you currently sexually active? Yes No
 Sexual preference (circle one): Heterosexual Lesbian Bisexual
 How many sexual partners in the last 1 year? _____
 In your lifetime: 1-5__ 5-10__ 10-20__ 20+__

Have you ever had a sexually transmitted disease (STD)? Yes No
 Hepatitis (Type?) _____
 Syphilis (when? treated?) _____
 Chlamydia (when? treated?) _____
 Gonorrhea (when? treated?) _____
 Genital Herpes (taking meds?) _____
 HPV (human papilloma virus) _____
 Genital warts? _____
 HIV _____
 OTHER _____

Have you ever had MRSA (Methicillin-resistant Staphylococcus aureus)?
 Yes No

(PLEASE PLACE AN "X" IN THE WHITE BOXES THAT APPLY)

PAST MEDICAL HX & FAMILY HX

	YOU	Mother	Father	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Brothers or sisters	Children	OTHER family member
Anemia										
Ashkenazi Jewish descent (Eastern European or Russian)										
Arthritis										
Asthma										
Birth defects (i.e. cleft palate, spina bifida.....)										
Clotting disorder, or deep vein thrombosis										
Blood disorders (ex. ITP, sickle cell...)										
Breast disorders										
Cancer, Breast										
Cancer, Colon										
Cancer, Ovarian										
Cancer, Uterine										
Colon polyps										
Diabetes										
Endometriosis										
Epilepsy										
Gallbladder disease										
Genetic disorders (i.e. mental retardation, cystic fibrosis...)										
Glaucoma										
Heart disease or MVP										
High cholesterol										
High blood pressure										
Kidney Disease/stones										
Mental Illness, type?										
Menstrual irregularities										
Osteoporosis										
Pelvic Inflammatory dis.										
Stroke										
Thyroid disease										
Uterine anomalies										
...Still Living?	X									
...Deceased at Age?	----									

DATE: _____

SIGNATURE: _____

UPDATED 2/1/17

List **Drug Allergies** (and the Reaction you had):

List **all medications** (include over-the-counter and supplements), **Doses**, the **Reason** you are taking, and **Who prescribes** it:

REVIEW OF SYMPTOMS

<p>Constitutional: Frequent Fatigue Excess weight gain Excess weight loss</p> <p>Eyes, Ears, Nose, Mouth: Frequent or severe headaches Frequent lightheadedness</p> <p>Breasts: Lumps Pain Swelling Nipple discharge</p> <p>Cardiovascular: Chest pain Fainting Swollen/Painful varicose veins Calf pain</p> <p>Respiratory: Frequent shortness of breath Frequent Hoarseness</p> <p>Gastrointestinal: Nausea/ Vomiting Frequent Diarrhea Frequent Constipation Frequent Heartburn/ reflux Abdominal Pain Blood in stool Hemorrhoids</p> <p>Genitourinary: Urgency Frequency Pain with urination Blood in urine Frequent Urine leakage Pain with intercourse Genital sores</p>	<p>Circle One: Present Past N/A Present Past N/A Present Past N/A</p> <p>Circle One: Present Past N/A Present Past N/A</p> <p>Circle One: Present Past N/A Present Past N/A Present Past N/A Present Past N/A</p> <p>Circle One: Present Past N/A Present Past N/A Present Past N/A</p> <p>Circle One: Present Past N/A Present Past N/A Present Past N/A</p> <p>Circle One: Present Past N/A Present Past N/A Present Past N/A Present Past N/A</p> <p>Circle One: Present Past N/A Present Past N/A Present Past N/A Present Past N/A Present Past N/A</p> <p>Circle One: Present Past N/A Present Past N/A Present Past N/A Present Past N/A Present Past N/A</p>	<p>Genitourinary (continued) Irregular periods Painful periods Heavy periods No periods Possible pregnancy? Abnormal vaginal discharge Significant PMS</p> <p>Integument (skin): New skin lesions Changes to moles/skin lesions</p> <p>Musculoskeletal: Joint pain Joint swelling Recent back pain</p> <p>Endocrine: Excess bodily hair growth Excess hair loss Cold intolerance Heat intolerance Acne Thyroid abnormalities/ treatment?</p> <p>Psychiatric: Frequent Anxiety Frequent Depression Suicidal thoughts Psychiatric treatment</p> <p>Hematologic/Lymphatic: Easy bleeding Easy bruising</p>	<p>Circle One: Present Past N/A Present Past N/A Present Past N/A Present Past N/A Present Past N/A Present Past N/A</p> <p>Circle One: Present Past N/A Present Past N/A</p> <p>Circle One: Present Past N/A Present Past N/A Present Past N/A</p> <p>Circle One: Present Past N/A Present Past N/A Present Past N/A Present Past N/A</p> <p>Circle One: Present Past N/A Present Past N/A Present Past N/A Present Past N/A</p> <p>Circle One: Present Past N/A Present Past N/A Present Past N/A Present Past N/A</p>
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LIST ANY OTHER SYMPTOMS BOTHERING YOU TODAY:

YOUR HEIGHT:

YOUR WEIGHT:

DATE: _____

SIGNATURE: _____