Patient History

Last Name: _____ First Name: _____ DOB: _____ Today's Date: _____

Primary Care Physician: _____ Referred By: _____

Reason for Visit:
Are you here for your Annual Well Woman Exam: Y [ ] N [ ]
If you are not here for your Annual Exam, please describe the reason for your visit today: _____
Have you been seen for this before: Y [ ] N [ ]
Do you have an Advanced Directive: _____ Do you have a Living Will or Medical Power of Attorney: _____

Allergies:
Please list any allergies you have to Medications. If you do not know, please write "unknown": _____

If you do have any allergies, please list the reaction you have: _____

Family History:
Please list if anyone in your IMMEDIATE family (Mother, Father, Brother, Sister) has or had any of the following:

Problem	Family Member (Mother, Father, Brother, Sister only)	Problem	Family Member (Mother, Father, Brother, Sister only)
Alcohol Abuse		High Cholesterol	
Anemia		High Blood Pressure	
Asthma/Enphysema(pls specify)		Incontinence	
Autoimmune Disease		Liver Disease	
Blood Transfusion		Migraines	
Birth Defects		Osteoporosis	
Breast Cancer		Ovarian Cancer	
Cancer		Rheumatic Fever	
Cervical Cancer		Seizure/Neurological	
Colon Cancer		Stomach/Intestinal	
Depression		Thyroid Problems	
Diabetes		Tuberculosis	
Heart Disease		Urinary Problems	
Hepatitis		Uterine Cancer	

Personal Medical History:
Check here if no changes since last visit. If you have never had any of these studies, please write "never".

Last Mammogram: _____ Last Pap: _____ Last Bone Density: _____ Last Colonoscopy: _____

GYN	**STDs**		
[ ] Abnormal Pap Smear	[ ] Hormonal Problems	[ ] Chlamydia	[ ] Syphilis
[ ] Breast Problems	[ ] Infertility	[ ] Genital Warts	[ ] Herpes
[ ] DES Exposure	[ ] Premenstrual Syndrome (PMS)	[ ] HIV	
[ ] Endometriosis	[ ] Sexual Problems	[ ] HPV	
[ ] Frequent Bladder/Urinary Infections	[ ] Vaginitis	[ ] Gonorrhea	
Past Medical			
[ ] Acne (Severe)	[ ] Cancer	[ ] Hepatitis	[ ] Ovarian Cancer
[ ] Alcohol Abuse	[ ] Cervical Cancer	[ ] Hep B Vaccine, Date:	[ ] Rheumatic Fever
[ ] Anemia	[ ] Colon Cancer	[ ] High Blood Pressure/HTN	[ ] Seizure/Neurological
[ ] Asthma/Emphysema	[ ] Depression	[ ] High Cholesterol	[ ] Stomach/Intestinal
[ ] Autoimmune Disease	[ ] Diabetes	[ ] Liver Disease	[ ] Thyroid Problems
[ ] Birth Defect	[ ] Flu Vaccine, Date:	[ ] Migraine Headaches	[ ] Tuberculosis
[ ] Blood Transfusion	[ ] Heart Disease	[ ] Osteoporosis	[ ] Urinary Problems
[ ] Breast Cancer			
Do you have any religious or any other objection to any form of medical treatment you would like to make us aware of? (i.e. refusal of blood transfusion)		Do you have a religious preference?	