PATIENT DATA

Name: ______________________ DOB ____________________ Today's Date: ________________

Age: _____ Race: _____________ Married ( ) Single ( ) Divorced ( ) Widowed ( ) Committed Relationship ( )

Occupation: _________________________ Name of PCP: _________________________________

Pharmacy Name/Phone Number ____

Drug Allergies: ____

Date of Last Menstrual Period: __________________________________ Cycles: Regular ( ) Irregular ( )

Have you had any abnormal pap smears in the past? Yes ( ) No ( ) If yes when? _______________

Date of Last Mammo __________ Date of Last Bone Density _______ Date of Last Pap ______________

Surgeries: Year: ________ Description: ____
Year: ________ Description: ____
Year: ________ Description: ____

Hospitalizations (other than surgeries):
Year: ________ Description: ____
Year: ________ Description: ____

Contraception: ____ How Long? _______________

Cigarettes: _______________ per day Alcohol: ______________ Drug Use: ______________

PREGNANICES:

Year	Hospital	City/State	Dur. Of Pregnancy	Type of Delivery	Anesthesia	Newborn Sex Wt.	Complications

FAMILY HISTORY:

	Age Living	Deceased	Health of Cause of Death
Father:			
Mother:			
Siblings:			

CIRCLE IF ANY BLOOD RELATIVE HAS HAD:

Ovarian Cancer	Heart Disease	Kidney Disease	Tuberculosis	Mental Disorder
Breast Cancer	High Blood Pressure	Diabetes	Tumors	Seizures
Colon Cancer	Hemophilia	Muscular Dystrophy	Mental Retardation	Polycystic Kidney

YOUR PAST MEDICAL HISTORY

	(yes) (no)		(yes) (no)		(yes) (no)
Pelvic Infection	( ) ( )	Diabetes	( ) ( )	Sexually Transmitted Disease	( ) ( )
Mental Disorder	( ) ( )	Thyroid Disease	( ) ( )	Liver or Gall Bladder Disease	( ) ( )
Arthritis	( ) ( )	Heart Disease	( ) ( )	High Blood Pressure	( ) ( )
Rheumatic Fever	( ) ( )	Drugs	( ) ( )	Breast Discharge or Mass	( ) ( )
Varicose Veins	( ) ( )	Phlebitis	( ) ( )	Blood Disorder	( ) ( )
Asthma	( ) ( )	Heart Murmur	( ) ( )	Blood Transfusion	( ) ( )
Pneumonia	( ) ( )	Seizures	( ) ( )	Broken Bones	( ) ( )
Hepatitis	( ) ( )	Kidney Disease	( ) ( )	Sinus Headaches	( ) ( )
Ulcers	( ) ( )	Kidney Infections	( ) ( )	Migraine Headaches	( ) ( )

SIGNATURE: ____