Today's Date: ____ / ____ / _____
Patient Name: _____
Preferred Pharmacy Name: _____
Preferred Pharmacy Phone #: _____
Reason for Visit: Annual ____ GYN ____ OB ____ Infertility ____ Problem ____
Last Pap: _____ Last Bone Density Scan: _____
Last Mammogram: _____ Last Colonoscopy:_____ Gardasil: Yes or No

Past Medical History (PMHx)			
	Yes		Yes
Abnormal Uterine Bleeding (Heavy Periods/ Clots)		Diabetes Type I (Insulin Use)	
Anemia		Diabetes Type II (Non insulin)	
Anxiety Disorder, Generalized		Diverticulosis	
Arthritis		Dysmenorrhea (Bad Menstrual Cramps)	
Asthma		Endocrine Disorder	
Bartholin Abscess		Endometriosis	
Bartholin Cyst		Fibroids	
Blood Disease / Disorder		Gallbladder Disease	
Blood Transfusion		GERD (Heartburn)	
Bowel Disorders		Glaucoma	
Breast Disease / Breast Cyst		Gonorrhea	
Breast Nodule		Headache / Migraine	
Cervical Dysplasia		Heart Disease	
Cervical Polyp		Hemorrhoids	
Chlamydia		Hepatitis	
	Yes		Yes
Hernia		Pain Abdominal, RUQ	
Herpes		Psychiatric Problems	
High Blood Pressure		Pulmonary Embolus	
HIV Infection		Rheumatic Fever	
Infertility		Seizures	
Irritable Bowel Syndrome (IBS)		Skin Disorder	
Kidney Disease		Syphilis	
Liver Disease		Thrombophlebitis	
Lung / Respiratory Disease		Thyroid Disorder	
Menopause Symptoms		Tuberculosis	
Mitral Valve Prolapse		Urinary Incontinence (Leaking)	
Musculoskeletal Disorder		Urinary Infections	
Neurologic Disease		Vaginitis / Vulvitis	
Osteopenia		Varicose Veins	
Osteoporosis			

Past Surgical History (PSHx)	
Surgery	Date

Medications (Meds)			
Drug	Dosage	Frequency	Reason

Allergies
Medications: No ____ Yes ____ (please describe):
Food: No ____ Yes ____ (please describe):
Allergic to Latex? No ____ Yes ____

Mother Father Brother Sister Grandmother (maternal) Grandmother (paternal) Grandfather (maternal) Grandfather (paternal) Aunt Uncle Mother Father Brother Sister Grandmother (maternal) Grandmother (paternal) Grandfather (maternal) Grandfather (paternal) Aunt Uncle							

Blood Clots / Deep Vein										
Breast Cancer										
Cervical Cancer										
Colon Cancer										
Diabetes										
Endometriosis										
Fibroids										
Heart Disease										
High Cholesterol										
Hypertension										
Osteoporosis										
Ovarian Cancer										
Stroke										
Uterine Cancer										

Reproductive History (RHx)	
Menstrual	
First Day of Last Period? ___ /___ /_____	Length of period in days: _____
Interval between periods: ____ to ____ days	Menopausal? Yes ____ No ____
Method of Birth Control:	
Pregnancy Vaginal Deliveries _____ C-Sections _____	

Total Pregnancy #	Full Term #	Premature #	Miscarriages #
Elective Abortions #	Ectopics #	Multiple #	Living #

Social History (SHx)	
Alcohol Use	Never ____ Current ____ Former ____
Tobacco Use	Never ____ Current ____ Former ____
Drug Use	Do you use recreational drugs? Yes ____ No ____
Occupation	
Marital Status	Married ____ Divorced ____ Single ____ Widowed ____
Sexual Activity	Are you sexually active? Yes ____ No ____ Not currently ____ Never____ Age of first coitus: ____
Safety	Is violence at home a concern for you? Yes ____ No ____