FEMALE PATIENTS

Patient Health Information

Date _____

Patient name: _____ DOB: _____

Patient's Care Team

Do you see any other health care providers (i.e. cardiologist, gynecologist, dermatologist)? If so please list their name, specialty, and phone number: _____

_____

Pharmacy

Please list your pharmacy and phone number: _____

Allergies

Drug Allergies: Are you aware of any drug (medication) allergies? (*circle one)* **YES** **NO**

If yes, please list all drug allergies: _____

_____

Environment/Inhaled/Food Allergies: Please list all other allergies _____

_____

Current Medications

Please list all prescribed medications, over the counter medications, supplements, and vitamins with appropriate dosages that you are currently taking: _____

_____

_____

Vaccinations

Please list any adult immunizations and dates: _____

_____

_____

Past Medical History

Please check all conditions and problem areas that apply to you.

____ ADHD	____ Coronary artery disease	____ Heart murmur	____ Osteoporosis
____ Allergies	____ DVT/blood clot	____ Hemorrhoids	____ Psych disorder
____ Anemia	____ Dementia	____ High blood pressure	____ Seizures
____ Anxiety	____ Depression	____ High cholesterol	____ Skin problems
____ Arthritis/Joint Disease	____ Diabetes	____ Kidney disease	____ Sleep disorders
____ Asthma	____ GERD (acid reflux)	____ Kidney stones	____ Stomach issues
____ Bladder/kidney problems	____ HIV	____ Liver disease	____ Thyroid problems
____ Bleeding disorder	____ Headaches	____ Memory loss	____ Vision problems
____ COPD/lung disease	____ Hearing problems	____ Mood disorders	____ Weight problems
____ CVA/stroke	____ Heart disease	____ Muscle/joint problems	Other: _____

Surgical History

Please list all previous surgeries and dates: _____

_____

Family History

Please list any medical conditions your family members have:

Mother: Alive, at age: _____ Health problems: _____

Died, at age: _____ Cause of death: _____

Father: Alive, at age: _____ Health problems: _____

Died, at age: _____ Cause of death: _____

Maternal Grandmother: Alive, at age: _____ Health problems: _____

Died, at age: _____ Cause of death: _____

Maternal Grandfather: Alive, at age: _____ Health problems: _____

Died, at age: _____ Cause of death: _____

Paternal Grandmother: Alive, at age: _____ Health problems: _____

Died, at age: _____ Cause of death: _____

Family History (continued)

Paternal Grandfather: Alive, at age: _____ Health problems: _____

Died, at age: _____ Cause of death: _____

Siblings: # of brothers: _____ Health problems: _____

# of sisters: _____ Health problems: _____

Social History

Smoking status: (*circle one*) Never smoker Former smoker Current every day smoker Current some day smoker

Smoking – how much? (*circle one*) (*note: PPW = pack per week, PPD = pack per day)*

None 1 PPW 2 PPW ¼ PPD ½ PPD 1 PPD 1 ½ PPD 2 PPD 3+ PPD

How many years have you smoked? _____ **When did you quit smoking? _____**

Occupation: _____

Education: (*circle one*) Less than 8th grade 2 year college 4 year college Post graduate

Sexual orientation: (*circle one*) Heterosexual Homosexual Bisexual

Marital status: (*circle one*) Married Single Divorced Domestic partner Widowed

Number of children: _____

Exercise level: (circle one) None Occasional Moderate Heavy

Diet: (*circle one*) Regular Vegetarian Vegan Gluten Free

General stress level: (*circle one*) Low Medium High

Passive smoke exposure: (*circle one*) Yes No

Chewing tobacco: (*circle one*) None 1/day 2-4/day 5+/day

Alcohol intake: (*circle one*) None Occasional Moderate Heavy

Alcohol years of use: _____

Drug use: _____

Caffeine intake: (*circle one*) None Occasional Moderate Heavy

Smoke alarm in home: (*circle one*) Yes No **Advance directive:** (*circle one*) Yes No

Sexually active: (*circle one*) Yes No **Protected sex:** (*circle one*) Always Usually No

Recent colonoscopy? (*Please list date of procedure***):** _____

GYN History (For female patients only)

Date of last menstrual period: _____ **Menses monthly?:** (*circle one*) Yes No

Frequency of cycle (every _?_ days): _____ **Duration of flow:** _____

Flow: (*circle one*) Light Moderate Heavy

Age when you first got your period? _____ **If postmenopausal, age at menopause?** _____

Current birth control method: _____ **Age at first child:** _____

Date of last mammogram: _____ **Date of last pap smear:** _____

Sexually active: (*circle one*) Yes No **History of STD's:** (*circle one*) Yes No

Did you get the HPV vaccine? (*circle one*) Yes No

Date of most recent bone density test: _____

Are you on hormone replacement therapy? (*circle one*) Yes No