Patient Name: ______________________________ DOB: _________________________

What are we seeing you for today? ____

Are you allergic to any medications? If yes which ones and what side affects did you experience?
____

Who is you Primary Care Physician? ____

Address: __________________________________Phone Number: ____________________

What Pharmacy do you use? __________________Location:__________________________

How did you hear about the office? ____

Email (to access patient portal): ____

Social History:

Occupation: _____________________________

Highest level of Education: ________________

Marital Status: Single Married Divorced Widow

Live alone or with others: _________________

Number of children: ______________

Alcohol Pre-Pregnancy: None Occasional Moderate Heavy

Alcohol intake: None Occasional Moderate Heavy

Alcohol Years of use: _____________

Smoking Pre-Pregnancy: YES/NO

Smoking-how much? _____________________

Tobacco-years of use: _____________

Illicit drugs pre-pregnancy: YES/NO

Illicit drugs: ________________________

Illicit drugs years of use: ____________

Is blood transfusion acceptable in an emergency? YES/NO

Advance directive: YES/NO

Caffeine Intake: Occasional Moderate Heavy

Exercise Level: Occasional Moderate Heavy

Guns present in home? YES/NO

Seat belts used routinely: YES/NO

General stress level: Low Medium High

Gynecological History:

Last Menstrual Cycle: ____________

Frequency of Cycle: ____________

Duration of Flow: ____________

Age of First Period: ____________

Age of first child: _____________

Current birth control: ____________

Age of Menopause: ____________

Date of last Pap smear: ________________

Date of last mammogram: ______________

Location of last mammogram: ___________

STI's/HPV ___________________________

Date of last Colonoscopy: _______________

Obstetric History:

Total Pregnancies: ________

Full Pregnancies: _________

Premature: ______________

Miscarriage: _____________

Abortions: _______________

Twins: __________________

Complications: _______________________

List of medications you take on a daily basis:

____

____

____

Personal/Family Medical History:

Cancer: __________________________________

Diabetes: ________________________________

High Blood Pressure: _______________________

High Cholesterol: __________________________

Headaches/Migraines: ______________________

Surgical History:

Procedure Name:	**Procedure Date:**
________________________	________________
________________________	________________
________________________	________________
________________________	________________