

# Patient History



Name (First)		(M.I.)	(Last)		Age	Date of Birth	
Address			City	State	Zip	Phone (H) ( )	Phone (W) ( )
Religion		Occupation			Employer		Phone (Other) ( )
Height	Social Security No.		Marital Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed		Family Physician		Referred By

Spouse/Guarantor			Insurance					
Name (First)		(Last)	Primary Insurance Carrier		ID No.	Group No.		
Social Security No.			Insurance Address			City	State Zip	
Date of Birth		Sex	Policy Holder/Insured		Date of Birth	Policy Holder Employer Relationship to Insured		
Address			Secondary Insurance Carrier		ID No.	Group No.		
City	State	Zip	Insurance Address			City	State Zip	
Phone (H) ( )		Phone (W) ( )		Policy Holder/Insured		Date of Birth	Policy Holder Employer Relationship to Insured	

Medications/Allergies	Social History		
Current Medications (Please list) <input type="checkbox"/> Not Applicable	Do you currently smoke? <input type="radio"/> Yes <input type="radio"/> No If yes, how much? _____ How often? _____ If no, have you ever smoked? <input type="radio"/> Yes <input type="radio"/> No Last time _____		
Drug Allergies (Please list) <input type="checkbox"/> Not Applicable	Do you:	If yes, how much?	How often?
Are you allergic to Latex? <input type="radio"/> Yes <input type="radio"/> No	Drink alcohol? <input type="radio"/> Yes <input type="radio"/> No		
	Drink caffeine? <input type="radio"/> Yes <input type="radio"/> No		
	Use non-prescription drugs? <input type="radio"/> Yes <input type="radio"/> No		

Family History (List any medical problems/illnesses)	
Mother <input type="checkbox"/> Not Applicable	Mother's Parents <input type="checkbox"/> Not Applicable
Father <input type="checkbox"/> Not Applicable	Father's Parents <input type="checkbox"/> Not Applicable
Siblings <input type="checkbox"/> Not Applicable	Aunts <input type="checkbox"/> Not Applicable
Cousins <input type="checkbox"/> Not Applicable	Uncles <input type="checkbox"/> Not Applicable

Gynecological History		
Date of Last Menstrual Period	Age Menstruation (period) began	
Interval of Menses (Number of days between periods)	Duration of Menses (days)	
Contraception Method: _____		
Have you had any exposure to: <input type="radio"/> DES <input type="radio"/> Vaginal Warts <input type="radio"/> Chlamydia <input type="radio"/> Gonorrhea <input type="radio"/> Yeast <input type="radio"/> Herpes		
Have you had a Mammogram? <input type="radio"/> Yes <input type="radio"/> No If yes, when? _____		
Have you had an Abnormal Pap? <input type="radio"/> Yes <input type="radio"/> No If yes, when? _____ How was it treated? _____		
Have you previously used oral contraceptives? <input type="radio"/> Yes <input type="radio"/> No How long? _____		
Do you have cramps during menstruation? <input type="radio"/> Yes <input type="radio"/> No If yes, rate degree of discomfort: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		

