Name: ______________________________

Date of Birth: ______________________________

Reason for Visit (Circle):

Annual Well Woman Exam   Pregnancy   Problem

If Problem, Please Explain: ______________________________

____

Allergies:

____

____

Medications with Doses:

____

____

____

____

____

Pharmacy with Street Crossing:

____

____

Social History:

Do you exercise? ______________

Do you Smoke? ______________

Do you drink alcohol? ______________

How much alcohol do you drink per day?

____

Do you use marijuana/cannabis? ________

Do you use any other drugs? ________

Because abuse and violence are so common in women's lives, we have begun to ask routinely. Are you in a relationship in which you have been threatened or physically harmed by your partner?

YES   NO

Medical History (Please Circle):

High Blood Pressure   Heart Attack   Stroke

Blood Clots   Asthma   COPD   Migraines

Anxiety   Depression   Hypothyroid   Diabetes

Cancer, what kind(s)? ______________

Additional Medical History: ______________

____

Surgical History (Please Circle) :

Gallbladder   Appendix   Breast Augmentation

C-Section   Shoulder/Hip/Knee Surgery

Additional Surgery History: ______________

____

Preventative Screenings:

Last Mammogram Date: ______________

Mammogram Results: ______________

Last Mammogram Location: ______________

Last Colonoscopy Date: ______________

Colonoscopy Results(Circle):

Normal   Abnormal

When is your next Colonoscopy Due?

____

Last Bone Mineral Density (BMD) Test for Osteoporosis: ______________

BMD Results: ______________

Do you have a family history osteoporosis? Y N

Don't forget the back →