

PATIENT HISTORY											
Name:		Date of Birth: Reason for Visit:									
Primary Care Provider:		How did you hear about us?									
		MOBILITY STATUS									
Do you use any equipmer	nt or need assistance in any physical act	ivity? Y N If yes (circle):									
Cane Walker Crutches	Knee Walker 1- Person Assist 2-	Person Assist Gait Belt Wheelchair Scooter Sit-to-Stand Device Lift Device									
	ALLERGIES	CURRENT MEDICATIONS									
Allergies to any medication	on? Y N										
If yes, list med and reaction	on:										
	OBACCO USE	HEA	ALTH MAINTENANCE								
Tobacco (circle all that ap	pply): Cigarettes Pipe Cigar E-Cigarettes	Туре	Date	Location							
Start Date:	Quit Date:	Mammogram									
Packs per day:		Bone Density									
Smokeless Tobacco: Sn	uff Chew	Colonoscopy									
Years:		PAP Smear									
Counseling Given: Yes	No	Cholesterol									
Comment:		Thyroid Check									
IMMUNIZATIONS	OB/GYN STATUS		GYN HISTORY								
Chicken Pox: Y N	Are you currently pregnant? Y N	Age of first period: Period Duration:									
Hepatitis B: Y N	Last Menstrual Period (LMP):	Period Pattern: Regular Irregular Menstrual Flow: Light Moderate Heavy									
HPV: Y N	Is this date approximate? Y N	Menstrual Control: Panty Liner Other:		Hospital Pad Tampon req Change:							
Influenza: Y N	Are you unsure of your LMP? Y N	Intermenstrual Bleeding: None Monthly Regular Irregular									
Pneumovax: Y N	Currently breast feeding: Y N	Dysmenorrhea: None Moderate Severe									
Tetanus: Y N	Date of + preg test (if necessary):	Dysmenorrhea Symptoms: Cramping Throbbing Nausea Diarrhea Headache									
MEDICAL HISTORY											
Anemia: Y N	Cancer: Y N	Emphysema: Y N	Heart Failure: Y N	Seizures: Y N							
Anxiety: Y N	Cataracts: Y N	Environmental Allergies: Y N	Heart Murmur: Y N	Sickle Cell Anemia: Y N							
Arthritis: Y N	Chronic Kidney Disease: Y N	GERD (acid reflux): Y N	HIV/AIDS: Y N	Stroke: Y N							
Asthma: Y N	Chronic Bronchitis: Y N	GI Ulcer: Y N	Hypertension: Y N	Substance Abuse: Y N							
Blood Clot: Y N	Depression: Y N	Glaucoma: Y N	Meningitis: Y N	Thyroid Disease: Y N							
Blood Transfusion: Y N	Diabetes: Y N	Heart Attack: Y N	Osteoporosis: Y N	Tuberculosis: Y N							

SURGERY												
	Туре			Date	:	Туре			Date			
SOCIAL HISTORY												
Alcohol Use: Y N Drinks per Week Glasses of Wine: Cans of Beer: Shots of Alcohol: Standard drinks or equivalent:												
Sexually Active: Y N Not Currently Birth Control/Protection: Partners: Male Female Comments:												
Drug Use: Y N Types: Cocaine Heroine Marijuana Oxycodone Other: Per Week: Comments:												
SOCIOECONOMIC												
Occupation: Employer:				Marital Status: Spouse Nan			Name:	Numb	er of Children:			
FAMILY HISTORY												
Are you adopted? Y N If yes, and do not know family history, may skip this section Number of Brothers: Number of Sisters:												
Family member with the following: Mother (M), Father (F), Sister (S), Brother (B), Maternal Grandmother (MGM). Maternal Grand Father (MGF) Paternal Grandmother (PGM), Paternal Grandfather (PGF)												
Diabetes:			Colon Ca		i (i Givi),	Tuternar Granaratiier	Anemia:					
Stroke:	troke:			Other Cancer:			Thyroid Disease:					
Heart Disease			Birth Defects:			Osteoporosis:						
High Blood Pressure:			Bleeding Disorder:			Depression:						
Breast Cancer:			Clotting Disorder:			Arthritis:						
Ovarian Cancer:			Blood Clot/Pulmonary Embolism:			Other:						
					OB HIST	ORY						
Number of P	regnancies:	Number	of Miscarriages: Number of Abortio			Number of Abortions:	S: Number of Living Children:					
Date of	Hospital	Type of	Delivery	Duration	Prob	lems with Delivery	Sex	Name of Child	Birth			
Delivery	Delivered At	(Vag/C-	Section)	of Labor			(F or M)		Weight/length			
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