

Updated 11/01/11

Name:	Age:	Date of Birth:	Today's Date:
Primary Phone Number:	E-mail Address:		
Referring Physician / Person:	Primary Care Provider:		
Preferred Pharmacy Name:	Pharmacy Phone Number:		

Please describe any special problems or symptoms that you would like to discuss.

PREVENTIVE HEALTH

	Date of last:		Date of last:		Date of last:
Pap		Blood Work		Bone Density	
Mammogram		Colonoscopy			

MEDICAL HISTORY

Please check any past or current medical problems for yourself or immediate, blood relative.

Grandparents:

X = Yourself M = Mother F = Father S = Sister B = Brother Maternal = MGM or MGF Paternal = PGM or PGF

	You	Family		You	Family
Autoimmune Disease (Lupus, MS, etc.)			Heart Disease		
Alzheimer's			Hemorrhoids		
Anemia			Hepatitis		
Arthritis			High Blood Pressure		
Bleeding Disorder			Irritable Bowel Syndrome		
Blood Clots in legs			Kidney Disease		
Blood Clots in lungs			Lung Disease, Asthma		
Blood Disorders			Mental Illness, Depression		
Cancer Breast			Migraine Headache		
Cancer Colon			Osteoporosis		
Cancer Ovarian			Seizure Disorder		
Cancers Other			Skin Disorders		
Diabetes			Stroke		
Drug/Alcohol Abuse			Thyroid Disorder		
Frequent Bladder Infections			Tuberculosis		
Gallbladder Disease or Gallstones			Ulcers		
Hearing Problems			Other:		

SURGERIES

Date:	Surgery:	Date:	Surgery:

HOSPITALIZATIONS (Non-Surgical)

Date:	Problem / Diagnosis:	Comments:

CURRENT MEDICATION

List any **MEDICATIONS** you are taking, to include birth control pills, Tylenol, Advil, Aspirin, other non-prescription medicine, vitamins, herbs.

Medication Name	Dose	Frequency of Dose	Medication Name	Dose	Frequency of Dose

Do you take Calcium? Yes No If yes, amount:

Do you take Vitamin D? Yes No If yes, amount:

Do you take a Multiple vitamin or Prenatal Vitamin? Yes No

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REPRODUCTIVE PREGNANCY HISTORY (continued)

PREGNANCY DETAILS # 5			PREGNANCY DETAILS # 6		
Date:	Type of delivery:	Complications:	Date:	Type of delivery:	Complications:
# weeks at delivery:	<input type="checkbox"/> Vaginal		# weeks at delivery:	<input type="checkbox"/> Vaginal	
Birth weight:	<input type="checkbox"/> C-section		Birth weight:	<input type="checkbox"/> C-section	
Sex of child:	<input type="checkbox"/> Elective abortion		Sex of child:	<input type="checkbox"/> Elective abortion	
Name:	<input type="checkbox"/> Miscarriage		Name:	<input type="checkbox"/> Miscarriage	
PREGNANCY DETAILS # 7			PREGNANCY DETAILS # 8		
Date:	Type of delivery:	Complications:	Date:	Type of delivery:	Complications:
# weeks at delivery:	<input type="checkbox"/> Vaginal		# weeks at delivery:	<input type="checkbox"/> Vaginal	
Birth weight:	<input type="checkbox"/> C-section		Birth weight:	<input type="checkbox"/> C-section	
Sex of child:	<input type="checkbox"/> Elective abortion		Sex of child:	<input type="checkbox"/> Elective abortion	
Name:	<input type="checkbox"/> Miscarriage		Name:	<input type="checkbox"/> Miscarriage	
PREGNANCY DETAILS # 9			PREGNANCY DETAILS # 10		
Date:	Type of delivery:	Complications:	Date:	Type of delivery:	Complications:
# weeks at delivery:	<input type="checkbox"/> Vaginal		# weeks at delivery:	<input type="checkbox"/> Vaginal	
Birth weight:	<input type="checkbox"/> C-section		Birth weight:	<input type="checkbox"/> C-section	
Sex of child:	<input type="checkbox"/> Elective abortion		Sex of child:	<input type="checkbox"/> Elective abortion	
Name:	<input type="checkbox"/> Miscarriage		Name:	<input type="checkbox"/> Miscarriage	
PREGNANCY DETAILS # 11			PREGNANCY DETAILS # 12		
Date:	Type of delivery:	Complications:	Date:	Type of delivery:	Complications:
# weeks at delivery:	<input type="checkbox"/> Vaginal		# weeks at delivery:	<input type="checkbox"/> Vaginal	
Birth weight:	<input type="checkbox"/> C-section		Birth weight:	<input type="checkbox"/> C-section	
Sex of child:	<input type="checkbox"/> Elective abortion		Sex of child:	<input type="checkbox"/> Elective abortion	
Name:	<input type="checkbox"/> Miscarriage		Name:	<input type="checkbox"/> Miscarriage	