



Patient Information

Please Fill Out Completely

Name: _____ Date: _____ DOB: _____ Age: _____

Phone Number: _____ Email Address: _____

Reason for today's visit: _____

If problem, when did it begin? _____

Last Menstrual Period: _____ Last Pap Smear: _____ Normal Yes / No

Do you Smoke? Yes / No

Family History: (Immediate family – Mother, Father, Sister, Brother)

_____ Diabetes _____ Hypertension _____ Ovarian Cancer

_____ Heart Disease _____ Breast Cancer _____ Thyroid Condition

_____ Stroke _____ Colon Cancer _____ Osteoporosis

Who in the family? _____

List all surgeries you have had: _____

A _____

Pertinent Medical History:

_____ Diabetes _____ Abnormal Bleeding _____ Hyperlipidemia

_____ Thyroid Condition _____ Number of Pregnancies _____ Endometriosis

_____ Breast Cancer _____ Number of Children _____ HPV

_____ Infertility _____ Pregnancy Complications _____ HSV

_____ STDs _____ Irritable Bowel _____ GERD

_____ Fibrocystic Breast Disease _____ History of Abnormal Pap Smear

Medications and dosages you are currently taking including birth control: _____

A _____

Allergies: _____

Have you had a colonoscopy? Yes / No If Yes, when _____

Have you had a bone dexa? Yes / No If yes, when _____