HEALTH INFORMATION

Name		*Date*			
Referred By		*DOB*		*Age*	
Date of Last Physical Exam		*Phone Number*			

SYMPTOMS CURRENTLY HAVING:	***ALLERGIES:***	
	Drug	***Other***
	Allergy to Latex .....Yes/No	

MEDICATIONS/SUPPLEMENTS:	
Drug/Dose:	*Drug/Dose:*
Drug/Dose:	*Drug/Dose:*
Drug/Dose:	*Drug/Dose:*
Drug/Dose:	*Drug/Dose:*
Drug/Dose:	*Drug/Dose:*

MENSTRUAL HISTORY:	***PRIOR PREGNANCIES:***
Last Menstrual Period *Date _____ Unknown Approx _____*	*How many children born alive _____* *How many still births _____* *How many premature births _____*
Menses *Are your cycles regular? _____* *How many days apart? _____* *Age of Onset (First Period)? _____*	*How many cesarean sections _____* *How many miscarriages _____* *Have you ever had twins? _____*

HEALTH MAINTENANCE (ENTER DATE AND RESULT)						
Immunizations	*Tdap*	*Flu*	*Pneumovax*	*Hep.A*	*Hep.B*	*Gardsil*
Pap				*Mammogram*		
Colonoscopy				*Bone Density*		

SURGERIES:	
Type/Year:	*Type/Year:*
Type/Year:	*Type/Year:*
Type/Year:	*Type/Year:*
Type/Year:	*Type/Year:*

SOCIAL HISTORY:	
Marital Status: (circle one) *Single Married Divorced Widowed Separated* *Do you use alcohol? Yes/No* *Do you use social drugs? Yes/No* *Do you use tobacco? Never Current Former* *Are you aware of any abuse in your past? Yes/No* *Type: (circle one) Physical Emotional Sexual*	*Have you been sexually active in the past ? Yes/No* *Are you currently sexually active? Yes/No* *Is your sex life satisfactory? Yes/No* *Do you exercise? Yes/No* *Do you wear a seat belt/helmet? Yes/No* *Education _____* *Occupation _____*

See Back →

PERSONAL HISTORY: (CIRCLE ALL THAT APPLY)			
Abnormal Pap Smear (circle one) Abnormal Cells HPV (Human Pap Virus) Other _____ Unknown	Clotting Disorder _____	Herpes (Genital)	Osteoporosis
	Depression	High Blood Pressure (Hypertension)	Pneumonia
	Diabetes	High Cholesterol (Hyperlipidima)	Pulmonary Disease (Lung)
Anemia	Dizziness	Hyperthyroid	Renal Disorder (Kidney)
Anxiety	Epilepsy	Hypothyroid	Seizure Syndrome
Arthritis	Gastrointestinal Problems _____	Infertility Problems	Urinary Incontinence
Asthma (Lung)	Headaches	Sexually Transmitted Disease (circle one) HPV (Human Pap Virus) HIV Syphilis Gonorrhea Chlamydia Trichomoniasis	
Back Pain	Heart Disease		
Bladder Disorder	Heart Murmurs		
Breast Lump	Hearing Loss	Kidney Stones	Weight Gain or Loss ___lbs
Cancer (if yes see below BRACA Testing)	Hepatitis	Liver Disease	Other _____
Cholecystitis (Gallbladder)	Herpes (Oral)/Cold Sores	Migraines	

PERSONAL HISTORY OF CANCER

Personal history of CANCER YES/NO If YES… Age of Diagnosis _____ Type_____

Are you of Ashkenazi Jewish descent? YES/NO

If YES to any of these questions, you may be a candidate for BRACA Testing

FAMILY HISTORY: (CIRCLE ALL THAT APPLY)

DISEASE	Mothers side/Fathers side	Relation	Age of Diagnosis	Comments
Birth Defects				
Depression				
Diabetes				
Eclampsia				
Endometriosis				
Heart Disease				
High Blood Pressure				
Multiple Births (twins)				
Seizure Syndrome				
Stroke Syndrome				
Pre-eclampsia				
Other				

FAMILY HISTORY OF CANCER

TYPE	Mothers side/Fathers side	Relation	Age of Diagnosis	Comments
Breast				
Ovarian				
Colon				
Endometrial (Uterine)				
Melanoma				
Other				

If YES to any of these questions, you may be a candidate for BRACA Testing