NAME _____ **DATE OF BIRTH** _____ **TODAY'S DATE** _____

PERSONAL MEDICAL HISTORY

Have you ever had the following:

YES	NO	
___	___	MIGRAINES
___	___	THYROID PROBLEMS
___	___	ASTHMA
___	___	BREAST DISEASE
___	___	HIGH BLOOD PRESSURE
___	___	BLOOD CLOTS (arms, legs, lungs)
___	___	STROKE
___	___	ANEMIA OR BLOOD DISEASE
___	___	HIGH CHOLESTEROL
___	___	SICKLE CELL DISEASE
___	___	BLOOD TRANSFUSION
___	___	HEPATITIS OR MONO
___	___	LIVER DISEASE
___	___	KIDNEY/BLADDER PROBLEMS
___	___	INFECTION OF UTERUS OR FALLOPIAN TUBES
___	___	FREQUENT VAGINAL INFECTION
___	___	GENITAL WARTS
___	___	STD (Gonorrhea, Syphilis, Chlamydia, Herpes)
___	___	IV DRUG USE
___	___	OVARY PROBLEMS
___	___	DIABETES
___	___	CANCER
___	___	PHYSICAL/SEXUAL ABUSE
___	___	EMOTIONAL/PSYCH PROBLEMS
___	___	MRSA

FAMILY HISTORY

Have your parents, grandparents, brothers/sisters, had any of the following:

YES	NO	
___	___	BREAST OR OVARIAN CANCER
___	___	OTHER CANCER (TYPE_____)
___	___	DIABETES
___	___	HEART ATTACK OR STROKE
___	___	HIGH BLOOD PRESSURE
___	___	HIGH CHOLESTEROL

MENSTRUAL AND PAP HISTORY

FIRST DAY OF LAST MENSTRUAL PERIOD _____

OF WEEKS BETWEEN PERIODS_____

HOW MANY DAYS DO YOU FLOW? _____

HAVE YOU EVER HAD AN ABNORMAL PAP? ☐ **YES** ☐ **NO**

If so, when? _____

PREGNANCY HISTORY

HOW MANY TIMES HAVE YOU BEEN PREGNANT? (INCLUDING NOW)_____ # OF LIVE BIRTHS_____

OF MISCARRIAGES OR ABORTIONS _____

PROBLEMS WITH PREGNANCIES:

_____

_____

CURRENT BIRTH CONTROL METHOD:

_____

MEDICATIONS (Strength & Dosage)

_____

_____

_____

_____

_____

_____

NATURAL SUPPLEMENTS/HERBS

_____

_____

_____

HOSPITALIZATIONS/SURGERIES & DATES

_____

_____

_____

ALLERGIES (medications, skin, latex)

_____

_____

_____

SEXUAL PARTNERS ☐ **MALE** ☐ **FEMALE** ☐ **BOTH**

HABITS

ALCOHOL ☐ **YES** ☐ **NO** AMOUNT_____

TOBACCO ☐ **YES** ☐ **NO** AMOUNT_____

RECREATIONAL DRUGS ☐ **YES** ☐ **NO** AMOUNT_____

CAFFEINE ☐ **YES** ☐ **NO** AMOUNT_____

DO YOU EXERCISE REGULARLY? ☐ **YES** ☐ **NO**

HOW OFTEN? _____

TYPE OF EXERCISE _____

(CONTINUED…)

NAME _____

OTHER SYMPTOMS

Are you currently having problems with (*please circle*):

GENERAL: FEVER / CHILLS /DECREASED ENERGY/ WEIGHT GAIN / WEIGHT LOSS

EARS, NOSE, THROAT: SINUS PROBLEMS / RINGING EARS / SORE THROAT

CARDIOVASCULAR: PALPITATIONS / CHEST PAIN / SWELLING IN LEGS

RESPIRATORY: SHORTNESS OF BREATH / CHRONIC COUGH / WHEEZING

GASTROINTESTINAL: DIARRHEA / CONSTIPATION / HEARTBURN / RECTAL BLEEDING/ NAUSEA

GENITOURINARY: PAINFUL INTERCOURSE / LEAKING URINE / PAIN WITH URINATION

MUSCULOSKELETAL: JOINT PAIN / BACK PAIN / MUSCLE WEAKNESS

BLOOD PROBLEMS: EXCESSIVE BRUISING / BLOOD CLOTS IN VEINS

OTHER: