**Medical History**

**Patient Name :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dob:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Do you have any drug or food allergies? NO \_\_\_\_\_ YES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. When was your last pap smear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Was your last pap smear normal: \_\_\_\_\_\_\_\_\_\_ or abnormal: \_\_\_\_\_\_\_\_\_
4. When was your last mammogram? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. When was your last bone density scan? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. When was your last colonoscopy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. When was your last flu Vaccine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. What is your activity level? Light \_\_\_\_\_\_\_, Moderate \_\_\_\_\_\_\_, Intense \_\_\_\_\_\_\_
9. Do you use any type of tobacco? Yes \_\_\_\_\_, No \_\_\_\_\_
10. Alcohol consumption? Never \_\_\_\_\_\_\_, Social \_\_\_\_\_\_\_\_, Every Day \_\_\_\_\_\_\_

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| **Pregnancies** |
| Times Pregnant? | Miscarriages? | Abortions? | Living Children? |

|  |
| --- |
| **Children Information** |
| Born Month & Year  | Weight at birth | Baby’s Sex | Gestational Weeks at delivery | Type of Delivery |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |

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| --- |
| **Menstrual History** |

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| Date of last period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Length: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age of first period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Current birth control method:  |

|  |
| --- |
| **Family Medical History** |
| Cancer / who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Diabetes / who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Heart Problems / who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hypertension / who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Kidney Problems / who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_Other Medical Problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Medications** |
| **Medication** | **Dosage** | **Frequency** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
| 7. |  |  |
| 8. |  |  |

Preferred Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_