PLEASE COMPLETE THIS PAGE FULLY

Patient Name ______________________________________Date of Birth____________________________

Primary Care Physician: ____________________Referring Physician: ______________________________

Chief Complaint (**WHY ARE YOU HERE**) ____

Last Pap: _________________________

Last Colon screening: _________________

Last Mammogram: ______________________

Last Menstrual Cycle: ______________

Prescription (Rx) Meds and the strengths (mg): ____

____

____

Medical Allergies:____

PLEASE USE BACK OF PAGE IF YOU NEED MORE SPACE TO WRITE PRESCRIPTIONS

What problems are you having: ____

____

Family History:

Mother	Living	Deceased	Cause: ________________________________
Father	Living	Deceased	Cause: ________________________________
Bro/Sis	#Living _____	#Deceased _____	Cause: __________________________

Family History:

Diabetes ______ Heart Disease _____ High Cholesterol _____ Colon Cancer _____
High Blood Pressure______ Uterine/Cervical/Ovarian/Breast Cancer _____ Other ___________

Surgeries: ____

#Pregnancies: _____ Deliveries: _____ Miscarriages: _____ Abortions: _____ Living children: _______

Illnesses during pregnancies: ____

Social History:			Type/Amount:
Tobacco Use	Yes	No	____
Alcohol/Drug Use	Yes	No	____
Domestic Violence	Yes	No	____
Seat Belt Use	Yes	No	____
Regular Exercise	Yes	No	____