Name _____ Date_____

Allergies: (Please list all allergies and reactions)

Allergy _____	Reaction _____	Allergy _____	Reaction _____
Allergy _____	Reaction _____	Allergy _____	Reaction _____
Allergy _____	Reaction _____	Allergy _____	Reaction _____
Allergy _____	Reaction _____	Allergy _____	Reaction _____

Medical History: (Please check any of the following that apply to you)

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Blood Transfusions
- ☐ CAD
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Cirrhosis
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fracture
- ☐ Gastric Ulcer
- ☐ Gastrointestinal Disease
- ☐ GERD
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Migraine
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Neurological Disorder
- ☐ Pulmonary Disease
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TIA
- ☐ Prostate Issues (men)

Surgical and Hospitalization History: (please list all applicable)

Surgeries & Dates: _____

Hospitalizations & Reasons: _____

Preventative Care: (please enter result and date of last, if applicable)

Bone Density:	Result _____	Date _____
Colonoscopy:	Result _____	Date _____
HIV Test:	Result _____	Date _____
GC/Chlamydia:	Result _____	Date _____
Mammography:	Result _____	Date _____
Pap Smear (if new):	Result _____	Date _____
PSA (men only):	Result _____	Date _____

Current Medications/Supplements and Dose:
(Include all HRT, and herbal remedies)

Rx _____ Dose _____

Rx _____ Dose _____

Rx _____ Dose _____

Rx _____ Dose _____

Rx _____ Dose _____

Supplements:

_____

_____

_____

Name _____ Date_____

Tobacco Use & History:

Are you currently a tobacco user? ☐ NO ☐ YES
Have you ever been a tobacco user? ☐ NO ☐ YES if yes, when did you quit? _____

Gyn History:

Date of last Period: ___/___/___ Frequency of Menstrual Cycle: _____ (e.g. "every 28 days")

Duration of Cycle: _____ (e.g." Lasting 4 days") Age of Menstrual Onset: _____ (e.g. "12")

Have you reached Menopause? ☐ NO ☐ YES, my last period was _____

Have you had a history of abnormal Pap Smears? ☐ NO ☐ YES (Please describe) _____

Are you sexually active? ☐ NO ☐ YES

Have you ever been treated for a sexually transmitted disease? ☐ NO ☐ YES (if yes, please describe below)

_____

Are you currently using birth control? ☐ NO ☐ YES (Please list method) _____
If IUD, Insertion date: ___/___/___, removal ___/___/___

Pregnancy History:

Total Number of Pregnancies: _____ Total Number of Children: _____ Total Premature Births: _____

Total Terminations: _____ Total Miscarriages: _____ Total C-Sections: _____

Family History: (Please select all applicable and list family member)

☐ Diabetes	_____
☐ Epilepsy	_____
☐ High Cholesterol	_____
☐ Hypertension	_____
☐ Thyroid Disease	_____
☐ Kidney Disease	_____
☐ Liver Disease	_____
☐ Osteoporosis	_____
☐ Pulmonary Disease	_____
☐ Stroke	_____

☐ Alcoholism	_____
☐ Anxiety	_____
☐ Asthma	_____
☐ Birth Defects	_____
☐ Cardiovascular Disease	_____
☐ Congestive Heart Failure	_____
☐ Cancer	_____
☐ CPOD	_____
☐ Crohn's Disease	_____
☐ Depression	_____