



Patient Name: _____ Practice: _____

Patient DOB: _____ Provider: _____

Patient Sex: ☐ Male ☐ Female**Active Medications** ☐ No Medications*** Complete as much medication information as possible**

	Brand/Generic Name	Start Date	Dose	SIG
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Allergies ☐ No Known Allergies**Problems List** ☐ No Chronic Problems

	Name	Reaction
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

	Name	ICD-9	Additional Information
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			



Patient Name: _____ Patient DOB: _____

Medical/Surgical History☐ No Known Past Medical History

	Disease	Year Dx	Mgmt/Procedure	Year Proc	Outcome/Status
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Family History☐ No Relevant Family History

	Family Member	Diagnosis/Problem	Age Onset	Comments
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Social History**Tobacco Use** ☐ yes ☐ no ☐ former**Drinks Alcohol** ☐ yes ☐ no ☐ formerYears Quit

Type	
Packs/Day	
Years Smoked	
Years Quit	

Type		Frequency	
Amount		Last Drink	

Caffeine Use ☐ yes ☐ no

Type		
Amt Daily		

Preferred Pharmacy Information

	Pharmacy Name	Phone	Fax	Address
1				
2				



Patient Name: _____ Patient DOB: _____

Gynecologic History

Age of Menarche Date of Last PAP Date of last Mammo
☐ normal ☐ abnormal ☐ normal ☐ abnormal

Premenopausal ☐ yes ☐ no
Perimenopausal ☐ yes ☐ no
Postmenopausal ☐ yes ☐ no Age Year Type

Hysterectomy ☐ yes ☐ no Type

Pregnancy History

Full Term Premature Abortions
Miscarriages Tubal-Ectopic Living Children

Birth History

Preg #	Sex	Year	Gestational Age	Weight	Delivery Type	Complications/Comments

Contraception/Safer Sex HistorySexual Orientation Sexually Active ☐ yes ☐ no ☐ PreviouslyPractices Safer Sex ☐ yes ☐ no ☐ Sometimes**Type of Birth Control**

☐ Condoms ☐ Birth Control Pill ☐ Tubal
☐ Diaphragm ☐ Ring ☐ Injection
☐ IUD ☐ Vasectomy ☐ Other: