NAME DATE OF BIRTH TODAY'S DATE

PHARMACY PRIMARY DR.

HAVE YOU EVER HAD:

	Yes	No
High blood pressure		
Heart Problems		
Obesity		
Lung Problems		
Diabetes		
Thyroid Disease		
Cancer		
Radiation or Chemo		
Anemia		
Blood Transfusion		
Blood Clot		

	Yes	No
Migraine Headaches		
Hospitalization		
Depression		
Addiction		
Kidney Problems		
Incontinence		
Liver Problems		
Stomach Problems		
Other		
Other		
Other		

About your Periods:

Date of Last Period
Age at First Period
Age at Menopause
Hormone replacement ?

About your Paps:

Last Pap
Abnormals
Procedures colpo cryo cone
HPV vaccine ?

About your Contraception:

Using now
Used in the past
Vasectomy yes no

Check if you have ever had:

Chlamydia
Cold sores
Genital warts
PID
Herpes
Other

About your pregnancies:

total pregnancies
full term babies
pre-term (before 36 wks)
abortions
miscarriages

vaginal deliveries
c-sections
Complications
breastfed

Current medications: **Dose ?**

Past surgeries:

Are you…………………… Single Married Divorced Widowed

Do you use……………….. Tobacco Alcohol Marijuana

Has anyone in your immediate family had:

Breast Cancer
Other Cancer
Diabetes
High Blood Pressure
Heart Disease
Blood Clot

When was your last:

Blood work
Mammogram
DEXA scan
Colonoscopy

Medication Allergies:

For Doctor: