



## PATIENT HISTORY

**Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_ **Social Security #** \_\_\_\_\_

1. **Reason for visit:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. **Family History:** Have you or any of your immediate relatives (mother, father, siblings, grandparents, spouse) experienced the following?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia          |
| <input type="checkbox"/> Stoke               | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Drug Abuse          | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Epilepsy        |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Glaucoma      | <input type="checkbox"/> Ulcer           |

3. **Please list any hospitalization, surgeries or major illnesses:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. **Have you had any of the following:**

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Eczema, Rashes, Hives |
| <input type="checkbox"/> Liver Disease, Hepatitis | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease       |
| <input type="checkbox"/> Venereal Disease         | <input type="checkbox"/> Mumps        | <input type="checkbox"/> Chicken Pox           |
| <input type="checkbox"/> Measles                  | <input type="checkbox"/> Rubella      | <input type="checkbox"/> German Measles        |
| <input type="checkbox"/> Rheumatic Fever          |                                       |  |

5. **Please list any medications your are presently taking?** \_\_\_\_\_  
 \_\_\_\_\_

6. **Please list any known medication allergies** \_\_\_\_\_  
 \_\_\_\_\_

7. **Date of last menstrual period?** \_\_\_\_\_  
**Date of last Pap smear?** \_\_\_\_\_ **Was it normal?** Yes \_\_\_ No \_\_\_  
**Date of last mammogram?** \_\_\_\_\_

8. **Have you ever been diagnosed with (if checked give date):**

<input type="checkbox"/> Yeast Infection	<input type="checkbox"/> Bacterial Vaginosis	<input type="checkbox"/> Trichomoniasis
<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Human Papilloma Virus	<input type="checkbox"/> HIV (AIDS)	<input type="checkbox"/> Herpes
<input type="checkbox"/> (Genital Warts)	<input type="checkbox"/> Other Infection	

<b>For Office Use Only</b>	_____