Female

Medical History

Patient Name: ______________________________________ Birth date: ___________________

Visit Date: _________________________

PAST MEDICAL HISTORY:

- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune disorder
- ☐ BPH
- ☐ Blood clots
- ☐ COPD
- ☐ Cancer
- ☐ Cerebrovascular accident
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ GERD
- ☐ Gallbladder disease
- ☐ Heart murmur
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel disease
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ Myocardial infarction
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Ovarian cysts, PCOS, pelvic masses or uterine problems
- ☐ Peptic ulcer disease
- ☐ Renal disease
- ☐ Seizure disorder
- ☐ Stomach / Duodenal ulcer
- ☐ Thyroid disorder

FAMILY HISTORY: ☐ Adopted

Has anyone in your immediate family ever had any of the following disease? If so, please select the disease, person in your family and enter their age.

Medical condition:	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Anxiety								
ADD/ADHD								
Alcoholism								
Allergies								
Alzheimer's disease								
Asthma								
Autoimmune disease								
Blood pressure								
Coronary artery disease								
Cancer (specify below)								
CVA (stroke)								
Depression								
Developmental delay								
Diabetes								
Eczema								
Hearing deficiency								
High blood pressure								
High cholesterol								
Irritable bowel disease								
Learning disability								
Mental illness								
Migraines								
Obesity								
Osteoarthritis								
Osteoporosis								
PVD								
Renal (kidney) disease								
Seizure disorder								

Other family history:

____

SURGICAL HISTORY: (list type and date):

____

Medical History (cont.)

Tobacco use:

Have you ever used tobacco? ☐ No/never ☐ Yes Have you used tobacco in the last 30 days? ☐ No ☐ Yes

Have you used smokeless tobacco in the last 30 days? ☐ No ☐ Yes

Smoking Tobacco use:

Tobacco type:	Use daily:	Usage per day:	Years used:	Packs year:	Age started:	Age stopped:
Cigarette						
Cigarillo						
Cigar						
Pipe						

Non-Smoking Tobacco use:

Tobacco type:	Use daily:	Usage per day:	Years used:	Packs year:	Age started:	Age stopped:
Chewing						
Smokeless						
Snuff						

Vaping:

Have you ever vaped? ☐ No/never ☐ Yes

What is your current vaping status? ☐ Current user ☐ Not a current user

Device type: ☐ Advanced Personal Vaporizers (APVs) ☐ Disposable ☐ E-Cigar ☐ E-Cigarette ☐ Rechargeable ☐ Other

Frequency: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Other

Current strength: ____% or _mg.ML

Vaping reason: ☐ Quit smoking ☐ Socializing ☐ Other ____________________________

Alcohol:

Do you drink alcohol? ☐ No ☐ Yes ☐ Formerly

Type of alcohol: ☐ beer ☐ liquor ☐ wine

Frequency: ☐ daily ☐ weekly ☐ monthly ☐ yearly ☐ occasionally ☐ rarely ☐ socially Amount: ___________

Last drink: ☐ today ☐ last night ☐ yesterday ☐ last week ☐ two weeks ago ☐ last month ☐ last year

How many times in the past year have you had 5 or more drinks in a day? _______

Drugs:

Any drug use? ☐ No ☐ Yes If yes, what kind of drug(s)? ______________________________

Any illegal drug use? ☐ No ☐ Yes Use of marijuana? ☐ No ☐ Yes

Caffeine:

Do you drink/consume caffeine? ☐ No ☐ Yes Caffeine per day: ______________________

Type of caffeine: ☐ chocolate ☐ coffee ☐ energy drinks ☐ soda ☐ tablets ☐ tea

Lifestyle:

Changes in sleep patterns: ☐ No ☐ Yes

Average number of hours of sleep per night: ________

Trouble falling asleep: ☐ No ☐ Yes

Difficulty staying asleep: ☐ No ☐ Yes

Frequent waking episodes at night: ☐ No ☐ Yes

Disrupted breathing, gasping, gagging, or choking for air during sleep: ☐ No ☐ Yes

Activity level: ☐ moderate ☐ sedentary ☐ vigorous

Health club member: ☐ Now ☐ Previously ☐ Never

Type of exercise: ___________________ Exercise frequency: _________________ Hours/week _______

Animals in the home: ☐ No ☐ Yes - ☐ Birds ☐ Dogs ☐ Rodents ☐ Cats ☐ Reptiles ☐ Other _________

Do you clean up after the animals? ☐ No ☐ Yes

Do you have a religious affiliation? ☐ No ☐ Yes

Do you practice your religion? ☐ No ☐ Yes

Is religion/spirituality an important part of your life? ☐ No ☐ Yes

Do you have spiritual beliefs? ☐ No ☐ Yes

Do you agree to blood/blood products? ☐ No ☐ Yes

# of current sexual partners? __________

I use condoms: ☐ Always ☐ Sometimes ☐ Never

Menstrual/Pregnancy History:

How old were you when you had your 1st menstrual period? _______________________

1st day of last menstrual period? ___________________

Are your meses regular (every 21-35 days) or irregular? ☐ Regular ☐ Irregular

How often do they come? ______________________

Is the flow: ☐ Heavy ☐ Normal ☐ Light

Do you have cramps? ☐ No ☐ Yes

Do you have bleeding between your menstrual periods? ☐ No ☐ Yes

Are you using a method to avoid pregnancy? ☐ No ☐ Yes. If so, what method do you use? ______________

Are you trying to achieve pregnancy? ☐ No ☐ Yes

How many times have you been pregnancy? _____________

Any breast concerns like nipple discharge, lumps or pain? ☐ No ☐ Yes

Do you do breast checks on yourself at home? ☐ No ☐ Yes

Medication Reconciliation

(Including vitamins, supplements and herbs)

Name of Medication:	Dose: (example: 100mcg, 10mg, etc.)	Frequency: (example: once a day, before meals, etc.)

Preferred pharmacy: ____

Allergies

(Medical, seasonal, food)

Name:	Describe your reaction: