



Date _____			
Print Last Name	First Name	Middle Name	
Age	Date Of Birth	Occupation	
Address	City	State	Zip

Main reason for visit:
Years of School _____

Medical History: Have you ever had or do you have now any problems with the following: Please Circle

Other: _____

#1	
#2	
#3	
#4	
#5	
#6	

History of any serious medical problems? Have you ever been hospitalized?

<u>Medicine</u>	<u>Amount</u>	<u>How often taken</u>	<u>Medicine</u>	<u>Amount</u>	<u>How often taken</u>



Charles K. Anderson, MD
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PRINT First Name _____ Last Name _____ DOB ____/____/____

Allergies: Please list medication and what reaction you had:

Family History: Has any member of your family, including parents, grandparents, brothers, or sisters ever had: (list person or persons involved):

Cancer: Person	How old were they when they had the disease	did this person die of the disease
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Breast Cancer:	_____	_____
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Colon Cancer:	_____	_____
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Ovarian Cancer:	_____	_____
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Uterine Cancer:	_____	_____
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Other Cancer:	_____	_____
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Diabetes _____	Heart disease _____
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High blood pressure _____	Kidney disease _____
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Lung disease _____	Blood clots _____
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Excessive bleeding (with dental extractions, child birth etc.) _____

Breasts:

Have you ever had a mammogram? _____ Date of last mammogram _____

Have you had a breast biopsy? _____

Colon:

Have you ever had a colonoscopy? _____ Date of last colonoscopy / result _____

Bone Density:

Have you had bone density screening? _____ Date: _____

Menstrual History:

What was the first day of your last normal menstrual period? _____

At what age did your menstrual periods begin? _____ How long are your usual menstrual cycles? (28-30 days apart?) _____

What is an average number of days you flow? _____ Any Cramps? _____ Is the flow heavy? _____

Date of your last PAP smear? _____ Have you ever had an abnormal PAP smear? _____ When? _____

If yes, please explain: _____

Age of Menopause, if applicable _____ Symptoms? _____

Birth Control History (if applicable):

Present method _____ last Used? _____

Problems with present or prior methods _____

Pregnancy History:

Number of: Pregnancies _____ Live births _____ Living Children _____ Miscarriages _____ Therapeutic Abortions _____

How old is your youngest child? _____ Birth weight: Largest _____ Smallest _____ Age at first pregnancy _____

What problems did you have with prior pregnancies, births or abortions? _____

Social History: Do you smoke? _____ How much? _____

How much alcohol do you drink? _____

What drugs have you used (marijuana, amphetamines, cocaine?) _____

Have you ever shared needles? _____

On a scale of 1 – 10 (1=very poor; 10=excellent) how would you rate: your job / work situation? _____ Home? _____

If applicable, how would you rate your relationship with your spouse / partner? _____

Have you ever had problems with your sex life? _____

Have you ever been hurt by sex? _____

Have you ever been forced to have a sexual encounter? _____

What is your height? _____ Recent weight? _____ Desired weight? _____

Are there any special concerns you would like to discuss with the doctor during your visit?

Thank You! The Medical History Form will go directly to your physician.