

Name _____

Chart # _____

Date of Birth _____

Today's Date _____

Medical History

Gender: Female Male Transgender (pronoun you prefer: _____)

Please complete this questionnaire (front and back) as accurately as possible only answering those questions that apply to you.
THIS INFORMATION WILL REMAIN CONFIDENTIAL.

What is the reason for your visit today? _____ First day of last menstrual period: _____

MEDICATION HISTORY:

Do you take any medication or use any drugs on a regular basis? YES NO

If yes, what kind and for what reason? _____

Have you taken any medication or drugs of any kind today? YES NO If yes, what kind and for what reason? _____

Have you ever had any of the following?

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Graves' disease	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	psychiatric care
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	pulmonary embolism
<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	rectal bleeding or sores
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Blood clot	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder
<input type="checkbox"/>	<input type="checkbox"/>	Breast mass	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	HPV	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell trait
<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroid	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis
<input type="checkbox"/>	<input type="checkbox"/>	Cushing's syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Testicular mass
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid nodule
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Fibroid	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer, GI
<input type="checkbox"/>	<input type="checkbox"/>	Genital warts	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>	Urinary tract infection
<input type="checkbox"/>	<input type="checkbox"/>	GERD	<input type="checkbox"/>	<input type="checkbox"/>	PID			

If yes, please explain: _____

ALLERGIES:

Are you allergic to any medications including iodine, shellfish or latex? YES NO If yes _____

SURGICAL / HOSPITALIZATION HISTORY:

Have you ever had surgery or been hospitalized? YES NO

If yes, give year and reason, include childbirth _____

Problems with Anesthesia? No Yes: _____

FAMILY HISTORY:

Have any family members had the following: Cancer, Diabetes, High blood pressure, Heart attack, Stroke or other serious illness?

Mother No Yes - indicate which illness _____

Father No Yes - indicate which illness _____

Grandmother No Yes - indicate which illness _____

Grandfather No Yes - indicate which illness _____

Siblings No Yes - indicate which illness _____

SOCIAL HISTORY:

Vaccinations:

Have you had Rubella (German Measles) or the vaccination for it? YES NO DON'T KNOW

Have you had Hepatitis B or the vaccination for it? YES NO DON'T KNOW

Have you had the HPV (Human Papilloma Virus) Vaccine? YES NO DON'T KNOW

