

Patient Name _____ DOB _____

FAMILY HISTORY

Illness	Relative	Age onset	Illness	Relative	Age onset
Y N Breast Cancer	_____	_____	Y N Ovarian Cancer	_____	_____
Y N Colon Cancer	_____	_____	Y N Other Cancer	_____	_____
Y N Heart Disease	_____	_____	Y N Hypertension	_____	_____
Y N Depression/Anxiety	_____	_____	Y N Stroke	_____	_____
Y N Thyroid Disease	_____	_____	Y N Osteoporosis	_____	_____
Y N Bleeding Disorders	_____	_____	Y N Mental Retardation	_____	_____
Y N Birth Defects	_____	_____	Y N Genetic Disease	_____	_____
Y N Diabetes	_____	_____	Y N Other	_____	_____

SOCIAL HISTORY

Tobacco Use Y N How Much _____ Number of Years _____
Alcohol Use Y N How Much _____
Recreational Drug Use Y N How Much _____ Number of Years _____
Calcium Intake Y N Calcium Supplement Y N _____
Caffeine Intake Y N How Much _____
Exercise Y N How often _____ Type _____

MEDICATIONS (INCLUDING OVER THE COUNTER)

Medication	Medication	Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

See Attached List _____

MENSTRUAL HISTORY

Age at first menstrual period _____
Cycle length _____ Flow length _____
Menstrual flow – Light _____ Moderate _____ Heavy _____

If you have stopped having menstrual periods, at what age did you have your last one _____

Date Updated and Reviewed _____

Patient Name _____ Date _____
 Date of Birth _____ Primary Care Physician _____
 Referred By _____ Physician Address _____
 Specialists _____

ALLERGIES (REACTIONS) _____ (_____)
 _____ (_____) _____ (_____)

MEDICAL HISTORY

Y N Heart Disease _____	Y N Hypertension _____	Y N High Cholesterol _____
Y N Stroke _____	Y N Bleeding Disorders _____	Y N Mitral Valve Prolapse _____
Y N Asthma _____	Y N Thyroid Disease _____	Y N HIV _____
Y N Osteopenia _____	Y N Osteoporosis _____	Y N Joint Replacement _____
Y N Diabetes _____	Y N Anxiety/Depression _____	Y N Migraines _____
Y N GERD _____	Y N Peptic Ulcer Disease _____	Y N Transfusion HX _____
Y N Cancer _____	Y N Seizures _____	Y N STD Exposure _____

Other _____

FAMILY PLANNING _____

OPERATIONS/HOSPITALIZATIONS

Date	Procedure	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OBSTETRICAL HISTORY G _____ T _____ Pt _____ A _____ L _____

Date	Type of Delivery (Complications)	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DEXA Scan Y N Date's _____
 Colonoscopy Y N Date's _____
 Gardasil Vaccine's Y N Date's _____

Date Updated and Reviewed _____