



Patient History Form	
Name:	Birth date:
Marital Status:	Occupation:

Allergies to Medications, Latex or Dyes	<input type="checkbox"/> None <input type="checkbox"/> Yes (please list)

Medications (Prescriptions, non-prescriptions, vitamins and supplements)	<input type="checkbox"/> None <input type="checkbox"/> Yes (please list)

Surgeries/Hospitalizations/Serious Injuries	Year

Immunizations	N	Y	N	Y
Hepatitis B Series				
Gardasil Series				
Chicken Pox immunization or disease				
Recent Pneumonia Vaccine				
Recent Flu Vaccine				
Positive TB Screening				

Health Maintenance	No	Yes	(Year)	No	Yes	(Year)
Colonoscopy						
Mammogram						
Pap Smear						
Bone Density						
Eye Exam						
Physical Exam						

Social History	No	Yes
Smoking		
Alcohol		
Caffeine		
Recreational Drugs		
Special Diet		
Regular Exercise		
Sexually Active		

Pack(s)/day /years Quit
 Drinks/day drinks/week
 Drinks/day
 If yes describe:
 If yes describe:
 Men Women Both

GYN History	OB History
Age of first mensus: () Menopause <input type="checkbox"/> N <input type="checkbox"/> Y (if yes Age:)	Total Number of Pregnancies: ()
Regular Periods <input type="checkbox"/> N <input type="checkbox"/> Y Painful Periods <input type="checkbox"/> N <input type="checkbox"/> Y	Full Term () Pre Term ()
PMS <input type="checkbox"/> N <input type="checkbox"/> Y – if yes describe	Miscariages () Abortions ()
Abnormal Pap: – if Yes approximate date ()	Tubal ()
Pain with intercourse: <input type="checkbox"/> N <input type="checkbox"/> Y	Content with sex life: <input type="checkbox"/> N <input type="checkbox"/> Y

