Patient Name:					Birth Date: / /	Date: / /
Marital Status	☐ Married	☐ Living with Partner	☐ Single	☐ Widowed	☐ Divorced	Sexually Active? ☐ Yes ☐ No
Contraception Method	Current:				Past:	
Menstrual History	LMP / /	PMP / /	Onset / /	Duration		

Current Medications	Medication Allergies

Social History

Please answer the following:	Yes	No	Notes
Smoke? # Years? Cigarettes per day?	☐	☐	
Alcohol? Drinks per day? Per week?	☐	☐	
Use recreational Drugs? Type?	☐	☐	
Exercise? Type: How often?	☐	☐	
Caffeine? Type: How much?	☐	☐	
Perform Self-Breast Exam? How often?	☐	☐	
Vitamins/Minerals Supplements? How much?	☐	☐	
Exposed to Health Hazards at Home or Work?	☐	☐	
Ever sexually abused, threatened or hurt by anyone?	☐	☐	

Mother: ☐ Living ☐ Deceased Cause: Age:	Father: ☐ Living ☐ Deceased Cause: Age:
Siblings: Number Living: Number Deceased:	Cause/Age(s)
Children: Number Living: Number Deceased:	Cause/Age(s)

Past Medical History/Review of Systems

Please (√) if you or member of your immediate family have now/ or in the past any of the following:

	Pt	Family	Comments		Pt	Family	Comments
Weight Loss/Gain				Abnormal Pap/Mammo			
Headaches/Migraines				Ovarian/Uterine Cancer			
Heart Disease				Other Cancer			
Breast Disease				Anemia/Blood Prob.			
Breast Cancer				Blood Transfusions			
Hypertension				Fatigue			
Respiratory/Asthma				Varicose Veins			
Hepatitis/Jaundice				Phlebitis/Blood Clots			
Gallbladder Disease				Gastro-Intestinal Dse			
Ulcers				Thyroid Disease			
Hernia				Diabetes			
Hemorrhoids				Epilepsy			
Rectal Bleeding				Neurological Problem			
Colitis				Arthritis/Osteoporosis			
Kidney Problems				Skin Disorders			
Bladder Infections				Tuberculosis			
Urine Incontinence				SexuallyTransmit Disease			
Depression/Anxiety				Infertility or DES			
Mental Illness				Other			

(Please continue on the next page)