Name: DOB: Today's Date:

PAST MEDICAL HISTORY

Have you had any of the following?

Anemia yes /no
Arthritis yes /no
Asthma yes /no
Cancer yes /no Type: ________
Cataracts yes / no
Congestive Heart Failure (heart unable to pump) yes / no
Coronary Artery Disease (heart attack/stent placement) yes / no
Diabetes yes / no
DVT (clot in veins) yes / no
Where:______________

Epilepsy (seizures, fits) yes / no
Gout yes/ no
GERD (acid reflux) yes/no
Hearing loss yes / no
Hepatitis yes / no
High Cholesterol yes / no
HIV positive: yes / no
Hypertension (high blood pressure) yes / no
Low Thyroid: yes / no
High thyroid: yes / no
Kidney Stones: yes / no

Osteoarthritis: yes / no
Pneumonia: yes / no
PE (clot in lungs): yes / no
Stroke: yes / no
Enlarged Prostate: yes / no
Tuberculosis: yes / no
Stomach Ulcer: yes / no
Valvular Heart Disease: yes / no
Bleeding Disease: yes / no

PAST SURGICAL HISTORY

Have you had any of the following?

AICD (defibrillator for heart): yes / no
Port-a-Cath: yes / no
Pacemaker: yes / no
Prostate Surgery: yes / no
Gallbladder Removal: yes/no
Hysterectomy: yes / no
Removal of Ovaries: yes / no

Removal of Thyroid: yes/no
Cataracts: yes / no
Knee Replacement: yes / no
Hip Replacement: yes / no
Tonsillectomy: yes / no
Right Mastectomy: yes / no
Left Mastectomy: yes / no
Bilateral Mastectomy: yes/no

Intestine Surgery: yes / no
Colon Cancer Surgery: yes/no
Removal of Kidney: yes/no
Heart Bypass: yes / no
Stent Placement: yes / no
Other:

GYN HISTORY

Age of first cycle: ______
LMP Date: _________
Menopause: yes / no
Year: ______
Hot Flashes: yes /no

Estrogen Used: yes /no
Years of Use: ____
Year Stopped: _____
Any Children: yes/no
# of Pregnancies: ____

# of Live Births:_____
# of Miscarriages: ___
Any Stillborn: yes / no
Any Abortions: yes / no
Age at First Pregnancy: ___

SOCIAL HISTORY

Are you… [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Sig. Other/Partner

Do you live … [ ] With Spouse [ ] Alone [ ] With Child(ren) [ ] Nursing Home [ ] Other

Tobacco Use: [ ] Never [ ] Currently using What year if discontinued use? _______
How many packs per day? _____ Per Year? _______
What type of tobacco? (cigarette [menthol/non-menthol]), cigar, pipe, snuff, chew) please circle all that apply

Alcohol Use: [ ] Never [ ] Former Use- Please list year you stopped _________

How many per day? ______ Per Week? ______ Per Month? ______ Per Year? ______

Any illicit drug use? yes / no What type? _________________ How often?________

What is your Primary Occupation: _________________________________ Secondary Occupation:__________________
Any Occupational Exposures? yes / no Please circle type: (radiation, asbestos, chemicals, mold)
Do you work as/in a(n): HVAC tech, Auto-mechanic, Construction, Chemical / Biological Plant, Farming (circle all that apply)

Name: **DOB:** **Today's Date:**

HEALTH MAINTENANCE

When was your last …

mammogram? ____________ Where was it performed?____________________________

PAP smear? ______________ Where was it performed?____________________________

colonoscopy?______________ Where was it performed?___________________________

EGD?____________________ Where was it performed?___________________________

self breast check?_____________

PSA (prostate lab): __________ Where was it performed?__________________________

stool guaiac? ____________ Where was it performed?___________________________

DEXA scan? ____________ Where was it performed?__________________________

FAMILY HISTORY:

Any Cancer history in your immediate family?

Mother Y / N What type? __________What age when diagnosed?____ Deceased? Y/N

Father Y / N What type? __________What age when diagnosed?_____Deceased? Y/N

Sibling's Y / N What type?_________What age when diagnosed? ____ Deceased? Y/N

Children's Y / N What type?_________What age when diagnosed?_____Deceased? Y/N

ALLERGIES

Drug Name: _________________________________What is the reaction: (itch, rash, etc)

Is the reaction mild / moderate / severe (circle all)

Environmental: ______________________________What is the reaction: (itch, rash, etc)

Is the reaction mild / moderate / severe (circle all)

MEDICATIONS

Please list the prescriptions you take along with their strength and amount per day.

Please list any over the counter, vitamins, supplements or herbals) you take and amount

Please list the name, phone number and address of your preferred pharmacy.

____

Do you have mail order benefits for prescriptions? Yes / no Who is your mail order carrier?____