Patient Name/Date of Birth: ________________________________ **Age**____________________

Reason for Your Visit:

____

____

HAVE YOU HAD ANY NEW PROBLEMS WITH:

Weight Loss/Gain	NO	YES _____
Fever	NO	YES _____
Vision	NO	YES _____
Hearing	NO	YES _____
Sore Throat	NO	YES _____
Chest Pain	NO	YES _____
Breathing	NO	YES _____
Coughing	NO	YES_____
Stomach Pain	NO	YES_____
Joint Pain	NO	YES_____
Skin Rashes	NO	YES_____
Leg Swelling	NO	YES_____
Seizures	NO	YES_____
Headaches	NO	YES _____
Depression/Anxiety	NO	YES _____
Bleeding	NO	YES _____
Urination	NO	YES _____
Urine Loss	NO	YES _____
Vaginal Discharge	NO	YES _____
Vaginal Dryness	NO	YES _____
Itching / Burning	NO	YES _____
Breast Lump / Discharge	NO	YES _____
Change in Periods	NO	YES _____
Contraception	NO	YES _____
Pelvic Pain	NO	YES _____
Problems with Intercourse	NO	YES ______

OTHER: ____________________________________

____

ALLERGIES TO MEDICATIONS: YES NO

LIST **MEDICAL**____________________________

ALLERGIES:_____________________________________

Social, Family, Other Medical History

SINCE YOUR LAST VISIT, HAVE **YOU** HAD ANY **NEW** ILLNESS, SURGERY OR HOSPITALIZATION? INCLUDE LABS & X-RAYS.

____

ANY LIFESTYLE CHANGES, INCLUDING:

Occupation	NO	YES	
Marital Status	NO	YES	
Alcohol Consumption	NO	YES	
Illicit Drug Use	NO	YES	
Tobacco Use	NO	YES	# packs _______
Exercise	NO	YES	

Times per week: ____________________

PERSONAL HISTORY:

Sexually transmitted diseases	NO	YES
HIV / AIDS	NO	YES
Abnormal Pap smears	NO	YES
Are you or have you been abused?	NO	YES
Have you had a Flu vaccine?	NO	YES
Have you had the Gardasil Vaccine?	NO	YES

HAVE THERE BEEN ANY NEW MEDICAL ILLNESSES IN IMMEDIATE FAMILY MEMBERS SINCE LAST VISIT? EX:(FEMALE CANCERS)

____

LIST **ALL CURRENT** MEDICATIONS/SUPPLEMENTS:

____

____

____

LATEX ALLERGY? : YES NO

(OFFICE USE ONLY)

Age _______ GP ___-____ LMP ____________ Menses q _________ days Duration ________ days Clots __________

Dysmenorrhea: _____________________ Contraceptive Method _____________________________________

Pap ________________ Last HPV Test ____/_____Pos___ Neg__ MMG______________ DEXA _____________

BMI ___________ Colonoscopy___________ HT_______ WT_________ BP______/______ P_________ Temp_________

Comments:

____

____

____

Nurse/MA________________________ ___Pamela Seaman, DO __ Date:___________________________

FP / IM ________________________________Consult requested by: ____