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PATIENT HISTORY FORM

Date_____/_____/_____ Last name:_____ First name:_____MI:_____
Date of birth: _____/_____/_____ Age:_____ Drug Allergies:_____
Date of last period: _____/_____/_____ Date of last mammogram: _____/_____/_____
Date of last pap smear: _____/_____/_____ Date of last colonoscopy: _____/_____/_____
Date of last bone scan: _____/_____/_____
Pregnancy history: Total_____ Premature birth_____ Miscarriages_____ Living Children_____ Other_____

What is the main reason for your visit today?
_____

If you are in pain, please indicate on a scale of 1-10, 10 being the most severe, how severe your pain is: _____

Location of the problem: Abdomen Genital Area Lower Back Breast Other:_____

Does anything help or make the problem worse? Standing Moving around Lying on my side

Other:_____

When did you first notice the problem? _____

HISTORY OF PRESENT ILLNESS

Please circle the main reason you came to see the doctor:

Pain **Protruded Organs** **Pap Smear** **Hormone Consult** **Frequent Urination**

Incontinence/Leakage **Irregular Bleeding** **Yearly Check-up** **Birth Control** **Discharge**

Second Opinion **Referring doctor (if applicable)/Primary Care Doctor: _____/_____**

Personal Medical History

Have you ever had an abnormal pap smear? ____ If so, was treatment required? ___

List any major illnesses List any prior surgeries Are you taking any medications?____ If so, please list:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you smoke? Yes No If yes, how much?_____ Do you drink? Yes No If yes, how much?_____

Family Medical History

List all serious illnesses in your immediate family.
(Example: diabetes, heart disease, stroke, breast cancer, ovarian cancer, colon cancer)

_____

_____

Physician Use Only: (Comments/Notes)	**# Answers**	**Level of Service**
	1 – 3	**1 or 2**
	4+	**3 – 5**