Date_____ SS#_____

Last Name_____ First Name_____ MI_____ DOB_____

Address_____

Home# ( )_____ Work# (919)_____ Cell# ( )_____ Email address _____

Emergency Contact_____ Relationship_____ Phone #_____

Reason for Visit_____

Allergies_____Reaction_____

Primary Care Physician_____

Last menstrual period_____Pap Smear: Date_____ Results_____ Ever had abnormal? Yes or No Any treatment?_____

Circle if you had: Chlamydia, Gonorrhea, Herpes, Trichomoniasis, Genital Warts or other_____

Have you received Gardasil/HPV vaccine?_____

Colonoscopy: Date_____ Results_____
Mammogram: Date_____ Results_____
Bone Density: Date_____ Results_____
Cholesterol Profile: Date_____ Results_____

Surgeries/Procedure: Date:
1._____
2._____
3._____
4._____

Past Medical History: (i.e. diabetes, hypertension, asthma etc.)
1._____
2._____
3._____
4._____

Occupation:_____With whom do you live?_____

Exercise: Yes or No ---How Often?_____ Alcohol Use: Yes or No---How often?_____

Tobacco Use: ☐ Yes or No ☐ How Often?_____

Medications:	Dose:	Medications:	Dose:
1._____	_____	5._____	_____
2._____	_____	6._____	_____
3._____	_____	7._____	_____
4._____	_____	8._____	_____

Contraceptive use (birth control)_____

PREGNANCY HISTORY (include miscarriages)

	Date	Child's Sex	Child's Weight	Circle Vaginal or C-Section
1				☐ Vaginal or C-Section ☐
2				☐ Vaginal or C-Section ☐
3				☐ Vaginal or C-Section ☐
4				☐ Vaginal or C-Section ☐

Family History: Mother: Health?_____ **Father : Health?_____**

Sister(s) How many?_____ Health?_____ **Brother(s) How Many?_____ Health?_____**

Breast Cancer: Who_____
Colon Cancer: Who_____
Ovarian Cancer: Who_____
Uterine Cancer: Who_____
Diabetics: Who_____
DVT (blood clots): Who_____

I hereby verify that the information I have provided above is correct to the best of my knowledge

_____ _____
Signed (patient, or parent if minor) Date