**Name: _____ Date of Birth: _____ Date: _____**

**Primary Care Doctor: _____**

**What are you following up for today?**

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**How would you like to receive reminders from our office?**
**Phone___Email___Secure Message on Portal___Decline to Specify___Do Not Wish to Receive Reminders___**

**CURRENT MEDICATIONS – Please list ALL medications you are currently taking including over the counter meds**

| Drug Name: | Strength: | Directions/How you take it: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Attach list if necessary**

**I give Women's Health Specialty Care permission to download my medication history: _____**
**Patient Signature**

**Pharmacy Name: _____ Phone #: _____**

**Pharmacy Address:**
**_____**

**ALLERGIES – Please list ALL types (Drug, seasonal, pets, environmental foods)**

_____

_____

## SOCIAL HISTORY

**Please provide the following information:**

**Alcohol Consumption:**

_____None _____Yes _____ Occasional/Social # of drinks per day _____ History of Abuse: _____None _____Yes

**Tobacco per day:**

_____None _____Yes #_____ Packs/day _____ How many years?

**If you previously smoked and stopped, When? _____ How long? _____ How many packs/day? _____**

**REVIEW OF SYSTEMS: Are you feeling any of these symptoms today?**

**Constitutional**
Anorexia
Aches and Pains
Chills
Easy Bruising
Fever
Fatigue
Generalized Weakness
Insomnia
Night Sweats
Sleep Apnea
Weight Gain
Weight Loss

**Eyes**
Blind
Blurred Vision
Double Vision
Glaucoma
Worsening Eyesight

**Allergic/Immunologic**
Drug Allergies
Environmental Allergies
Food Allergies
Seasonal Allergies

**Neurological**
Balance Problems
Disoriented
Dizzy Spells
Headache
Lack of Alertness
Leg or Arm Weakness
Memory Loss
Numbness/Tingling
Stroke
Speech Problems
Tremors

**Endocrine**
Diabetes
Excessive thirst
Tired/Sluggish
Too Hot/Cold

**Gastrointestinal**
Abdominal Cramps
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowel Habits
Constipation
Diarrhea
Flatulence
Gas
Hemorrhoids
Indigestion/heartburn
Irregular Bowel Movements
Nausea/vomiting
Rectal Bleeding
Tarry Stool

**Cardiovascular**
Chest Pain/Angina
Palpitation
Shortness of Breath
Swelling

**Skin**
Acne
Boils
Changing Moles
Persistent Itch
Pigment Change
Skin rash

**Musculoskeletal**
Back Pain
Joint Pain
Muscle Cramps
Muscle Weakness

**Ear/Nose/Throat**
Sinus Problem

**Genitourinary**
Back Pain
Bedwetting
Blood in Urine
Dribbling
Burning on Urination
Hesitancy
Infertility
Leak after voiding
Leak when cough/sneeze
Low Libido
Lower abdominal pain
Not Emptying
Painful Intercourse
Rush to get to bathroom
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Tract Infections
Urine retention
Vaginal Bleeding
Vaginal Discharge/Problems
Waking at night to void
Weak Stream

**Respiratory**
Frequent Cough
Shortness of breath
Wheezing

**Hematological/Lymphatic**
Swollen Glands
Blood clotting problem
Bleeding Problem

**Psychologic**
Anxiety
Depressed
Generally satisfied with life

Other: _____

_____

Is there anything you would like us to add to your medical history?_____

_____

Is there anything you would like us to add to your surgical history?_____

_____

Is there anything you would like us to add to your family history?_____

_____

Have you been diagnosed with high blood pressure?_____

Have you been diagnosed with Diabetes?_____

Have you had a colonoscopy within the last 9 years or a fecal occult blood test within the last year? If so, when?_____
_____

Have you had a pneumonia vaccination? If so, when? _____

Have you had a influenza (flu) shot this season? If so, when? _____

Have you ever had a Heart Attack, Bypass Surgery, Stent, or any other Vascular Diseases?_____