NAME:_____ DATE OF BIRTH:_____

GENDER AT BIRTH: Male _____ Female _____

CONCERNS TODAY: _____

_____

_____

PREVIOUS/ONGOING MEDICAL CONDITIONS:_____

_____

SURGERIES/ACCIDENTS/INJURIES:_____

_____

FIRST DAY OF LAST MENSTRUAL PERIOD: _____ DATE OF LAST PAP TEST: _____

Ever had an abnormal Pap test? Y N

If you, any treatment for abnormal Pap? Circle one: biopsy cryotherapy laser surgery

ALLERGIES (what is the reaction?):

_____

MEDICATIONS (prescriptions, over-the-counter, supplements):

_____

_____

PERSONAL HABITS:		How much?	How Often?
Tobacco Use/Vaping	Y N	_____	_____
Alcohol Use	Y N	_____	_____
Marijuana Use	Y N	_____	_____
Other recreational drugs	Y N	_____	_____
Exercise	Y N	_____	_____

Do you consider yourself: Heterosexual __ Homosexual __ Bisexual ___ Transgender __ Queer __

Something else _____

In a sexual relationship? Y N Partner(s) are Men ___ Women ___ Both ___

How do you prevent sexually-transmitted infections? _____

How do you prevent pregnancy? _____

FAMILY MEDICAL HISTORY:

Please indicate blood relatives (mother, father, sister, brother, grandmother, grandfather, aunt, uncle) with any of the following conditions:

Condition	Relative	Condition	Relative
Anxiety/Depression	_____	Colon Polyps	_____
Bleeding/Clotting Disorder	_____	Early Death	_____
Cancer (Type?)	_____	Mental Illness	_____
Diabetes (Type? Insulin?)	_____	Stroke	_____
Heart Problems	_____	Suicide	_____
High Blood Pressure	_____	Thyroid Disorders	_____
Rheumatoid Arthritis	_____	Other	_____

PLEASE MARK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE HAD RECENTLY:

CONSTITUTIONAL
- ☐ Weight gain/loss
- ☐ Chills
- ☐ Fever
- ☐ Fatigue
- ☐ NONE

EYES
- ☐ Change in vision
- ☐ Blurred vision
- ☐ NONE

EARS, NOSE, THROAT
- ☐ Ear pain
- ☐ Change in hearing
- ☐ Nasal congestion
- ☐ Frequent runny nose
- ☐ Sore throat
- ☐ NONE

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ Swelling of the feet and/or ankles
- ☐ NONE

RESPIRATORY
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ NONE

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Acid reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ NONE

URINARY
- ☐ Frequent urination
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Urinary incontinence
- ☐ NONE

FEMALE REPRODUCTIVE
- ☐ Vaginal discharge
- ☐ Pelvic pain
- ☐ Irregular periods
- ☐ Sexual concerns
- ☐ NONE

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Joint swelling
- ☐ NONE

SKIN/BREAST
- ☐ Rash
- ☐ Dry skin
- ☐ Breast mass/lump
- ☐ Nipple discharge
- ☐ NONE

BLOOD/LYMPHATIC
- ☐ Easy bruising
- ☐ Excessive bleeding
- ☐ Swollen glands
- ☐ NONE

ENDOCRINE
- ☐ Intolerance to heat or cold
- ☐ Excessive thirst
- ☐ NONE

NEUROLOGIC
- ☐ Headaches
- ☐ Dizziness
- ☐ Memory loss
- ☐ NONE

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Sleep problems
- ☐ NONE

ANY OTHER CONCERNS/SYMPTOMS?

_____