Personalized Women's Healthcare
Medical History

Name_____Date_____Age_____

Drug Allergies_____Medications_____

Referred by: Physician_____ Friend_____

Prescription Refills Needed? _____

What concerns bring you to the office? _____

Last Menstrual Period _____ Last Pap Smear _____ Last Mammogram _____

Last cholesterol test _____ Last Colonoscopy _____ Last Osteoporosis test _____

Alcohol YES / NO Smoking YES / NO Drug Use YES / NO Exercise YES / NO

Type of Birth Control _____ Need information about Birth Control? YES / NO

Past Medical History:

Diabetes _____

Heart Disease _____

Lung Disease _____

Hypertension _____

Liver _____

Kidney _____

Neurologic _____

Blood Vessels _____

Thyroid _____

Other _____

Surgery:

Breast _____

Tonsils _____

Hysterectomy _____

Orthopedic _____

Appendix _____

Gallbladder _____

Pregnancy # _____

Vaginal Deliveries #_____

C-Section #_____Miscarriage # _____

Family History / Relatives

Breast Cancer _____

Female Cancer _____

Birth Defects _____

Bleeding/Clotting Disorder _____

Diabetes _____

Other_____

LOCAL PHARMACY NAME, ADDRESS, TEL NO: _____

MAIL ORDER PHARMACY NAME, ADDRESS, TEL NO: _____