

PATIENT NAME _____ PHARMACY _____ DOB _____ AGE: _____

PAST OR PRESENT ILLNESS (circle all that apply):
 NONE OTHER _____
 Diabetes Asthma Hepatitis Cancer
 Heart Disease Thyroid Disorder Anemia
 Liver Disease Kidney Disease Blood Clotting Disorder
 Depression Anxiety High Blood Pressure
 High Cholesterol Seizure Disorder

SURGERIES (Please include year): NONE

FAMILY HISTORY (Diabetes, Heart Disease, etc):

Relative	Diagnosis	Age
(Example)Mother	Diabetes	40
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIFESTYLE/RISK FACTORS:
 Alcohol? Less than 2 beers per day
 More than 2 beers per day None
 Condom Use? No Occasionally Yes
 Diet? Balanced Overeating Undereating
 Current drug Use? Heroin Inhaled Marijuana
 Other(s) Downers Uppers None
 Last menstrual period? _____ Male
 Physical Activity/Exercise?
 Mild Exercise Occasional Vigorous Exercise
 Regular Vigorous Exercise Sedentary (no exercise)
 Have you ever been sexually active? Yes No
 Are you currently sexually active? Yes No
 Number of Partners in the last year? _____
 Have you ever had a Sexually Transmitted infection?
 Yes No
 If so, what? Chlamydia Trichomonas
 Herpes Gonorrhea Syphilis HIV
 Tobacco Use?
 Current User: Packs per day _____
 Decreasing Tobacco Never Recently Quit

MEDICATION(S):
 Medication Allergies: NONE SEE LIST

 Current Medications & Prescribing Doctor: NONE

Immunizations

Rubella Vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Hepatitis B Vaccine Series	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Gardasil (HPV) Series	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Flu Shot (this year)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

Emotional History

When you feel sad do you...
 bounce back quickly
 feel sad for 2 weeks or more

How often do you feel nervous, anxious or worried?
 Daily Weekly Monthly Seasonal

Social History

Yes No Are you adopted?
 Yes No Someone hits, slaps, kicks, or hurts you?
 Yes No Someone who often says hurtful or mean things?
 Yes No Afraid of your partner(s)/other
 Yes No Alcohol and/or drug problems in your life?
 Yes No Are others concerned about your alcohol/drug habits?
 Yes No Parents aware of your visit today?

Pregnancy History

NO PREGNANCY (SKIP THIS BOX)

Live Births _____ Date(s) _____
Premature Births _____ Date(s) _____
Tubal Pregnancies Births _____ Date(s) _____
Abortions _____ Date(s) _____
Living Children _____ Date(s) _____
C-Sections _____ Date(s) _____
Miscarriage(s) _____ Date(s) _____

Please mark if you have had any of the following problems with any pregnancy with you or in your immediate family:

- Gestational Diabetes Genetic Abnormalities
- High Blood Pressure Preterm Labor
- Two or more miscarriages Stillborn
- Baby with heart defect
- Baby born too soon or weighing less than 5 ½ pounds

Sexual History

Age when you first had sex? _____

How many times _____ month/year are you having sex?

Have you ever been sexually abused/raped?

Yes No

Does your partner have sex with females?

Yes No

Does your partner have sex with males? Yes No

Does your partner have sex with both male and female? Yes No

Are you and your partner only with each other?

Yes No

Do you think of yourself as:

- Lesbian, gay or homosexual
- Straight or heterosexual
- Bisexual
- Something else
- Don't know

Do you have sex with..

Male? Oral Anal

Female? Oral Vaginal Anal

Males Only

Yes No Do you perform self testicular exams?

Yes No Have you had a vasectomy/sterilization?

Females Only

Menstrual Cycle

First day of your last period: _____

Was your last period normal? _____

Age when period started: _____

Periods come every _____ days

Bleeding lasts _____ days

Periods are: Regular Irregular Painful

Flow is: Light Normal Heavy

Pap History

Last Pap smear: _____

Was it normal? _____

Have you ever had an abnormal pap smear? Yes No

If so, when? _____

Did you receive any treatment? _____

Breast Exam

Do you do Self Breast Exam? Yes No

Birth Control

Current form of birth control: _____

Any side effects? _____

Other forms of birth control used in the past:

Any side effects? _____

Reproductive Life Plan

Have you ever been pregnant? Yes No

Do you have plans for future pregnancy? Yes No

If yes, how many? _____

At what age would you like to have children? _____

How far apart would you like your children to be? _____

If you were pregnant would you be happy

Yes No

Would it be difficult for you to support a child currently?

Yes No

What will you do if you become pregnant?

PATIENT SIGNATURE _____ **DATE:** _____

PATIENT NAME (PLEASE PRINT) _____