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PATIENT HISTORY

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Name _____ DOB _____Age _____ Today's Date _____

Preferred name:_____ Pronouns:_____

Sex: Female/Male Gender _____ Marital Status: Single Married Partnered Divorced Separated Other

What is the one most important symptom or concern you would like addressed today? _____

Any other concerns if time allows? _____

For Female patients only: First day of last menstrual period _____ Method of birth control _____
Periods are: light moderate heavy Periods come every _____ days and last _____ days
Date of last pap smear_____ Have you ever had an abnormal pap? YES/NO
Date of last mammogram _____ Do you practice monthly breast self exams? YES/NO
Have you ever been pregnant? YES/NO How many times? _____ How many children do you have? _____

Have you ever been emotionally or physically abused? YES NO

Are you sexually active? YES/NO What is your sexual preference? _____
Do you have any problems with sexual relations? YES/NO If Yes, explain _____
Have you ever had any of the following Sexually Transmitted Infections? Genital Herpes/Chlamydia/Gonorrhea/HIV/HPV
Are you interested in HIV/other STI testing? YES/NO

Do you use any tobacco products? YES/NO
Have you used any tobacco products in the past?
Please list: _____
Do you drink alcohol? How many per day/week_____
Do you use recreational drugs? YES/NO

Are you satisfied with your eating habits? YES/NO
Does your weight affect the way you feel about yourself? YES/NO
Do you restrict, binge or purge? YES/NO
Do you exercise regularly? YES/NO

In the past 2 weeks have you had little interest or pleasure in doing things or felt down, depressed or hopeless? YES/NO
Have you ever been diagnosed with a mental illness? YES/NO

Please List all medications (including supplements)_____
_____
Are you allergic to any medication(s)? YES/NO IF yes, explain_____

List any **surgery** history (Procedure and Year) _____

Family History *please indicate **who and at what age** any family members diagnosed with the following:*

Diabetes _____ High Blood Pressure _____ Heart Attack _____
Stroke _____Thyroid Disease _____ Breast Cancer_____
Cancer of Uterus and or Ovaries _____ Blood Clot/Blood Disorders_____
Seizures _____ Colon Cancer _____ Osteoporosis _____
Disordered eating_____