Patient Name:

Age: Height: BMI: Last Menstrual Period:

Drug Allergies:

List any previous operations:

Please list any current medications taken on a regular basis:

List any current refills needed:

Please list any cancer in the family:

Please list any unusual health conditions in your family:

Please list any contraception you are currently using:

Has any member of your family had a heart attack or stroke at these ages:

Male < 55 Yes No Female < 65 Yes No

How many times have you been pregnant?

How many children do you have?

Do you smoke cigarettes? Yes No

Do you use illegal drugs? Yes No

Do you average more than 3 or 4 alcoholic beverages per day?

Do you have abnormal menstrual bleeding?

Do you have any pain with intercourse?

Do you have any leakage of urine?

If you are younger than 40:

- Are you getting 1200 mg of calcium per day? Yes No
- Do you take vitamin D? Yes No

Do you feel safe and secure in your current living situation? Yes No

Would you like to speak to a social worker on a confidential basis? Yes No

For the following health screenings, please give the approximate date of your most recent testing:

Cholesterol: Pap Smear: Colonoscopy(if > 50):

Glucose: Mammogram:

Thyroid: Bone Density: Glaucoma (if > 65):

Primary Care Physician:

Reason for visit: