PATIENT HEALTH SUMMARY Name: _____ Date: _____

What is the main reason you are here to see the doctor today? _____

_____

What prior treatment have you had for this? _____

Did someone refer you to this office? If so, who? _____

Local Pharmacy:_____ Mail Order Pharmacy:_____

List any medical problems or health conditions you have (please also list year problem was diagnosed).
(YEAR / Condition)

_____

_____

_____

_____

List any surgeries, procedures, or hospitalizations you have had since childhood (Give year, if known).

_____

_____

_____

Any family history of : ☐ Breast cancer ☐ Ovarian cancer ☐ Uterine cancer ☐ Colon cancer ☐ Other cancer
☐ Diabetes ☐ Heart disease ☐ Stroke ☐ Other: _____

Are you: ☐ Married ☐ Divorced ☐ Remarried ☐ Long-term partner ☐ Single ☐ Widowed
Are you: ☐ Sexually active ☐ No sexual partner ☐ Stopped having sex at age ____ ☐ Never had sex
Who lives with you? ☐ Spouse/partner ☐ #_____ children ☐ Other: _____
Do you work outside the home? If so, what type of work? _____

Do you smoke? ☐ No ☐ Yes: _____ packs/day ☐ I want to quit ☐ I've tried to quit ____ times.
Do you drink alcohol? ☐ No ☐ Yes: Rarely Occasionally/Socially Regularly More than I think I should
Do you exercise regularly? ☐ No ☐ Yes: 3 x a week or more Occasionally Rarely Never
Do you use street drugs? ☐ No ☐ Yes: Types/comments:_____

Age of first period: _____ Date of last period: ____/____/____ ***or:*** I stopped menstruating at Age: ____
Is your period regular? ☐ yes, it comes every _____days, and the menstrual bleeding lasts for _____ days
☐ No (explain): _____
Any problems with your period? _____
Do you ever leak urine by accident? ☐ No ☐ Yes→EXPLAIN: _____

Birth control method: ☐ None ☐ Pills ☐ Condoms ☐ Tubal ligation ☐ IUD ☐ Rhythm ☐ Other
Are you trying to conceive? ☐ Yes ☐ No ☐ No, but I'm open to getting pregnant
Any pain with intercourse? ☐ No ☐ Yes→EXPLAIN: _____
Do you have any other concerns about intercourse? _____

Total # of pregnancies: _____ Any birth complications? _____
# of vaginal deliveries: _____ # of C-sections: _____ # born premature (More than 3 weeks early): _____
# of miscarriages: _____ # of abortions: _____ Birth weight of largest baby? _____lbs. _____oz.

Pap smear history: Last pap smear (year): _____ Your age at first pap smear (approximately): _____
How often do you get a pap smear? ☐ Every year ☐ Every ____ years ☐Other: _____
Were you ever told you had an abnormal pap smear? ☐ No ☐ Yes→ Explain: _____
Were you ever treated for a pap smear problem? ☐ No ☐Yes→ Explain: _____
_____