BASELINE PATIENT HISTORY AGE 50 AND OLDER

Date:		Name:		DOB:		Age:	

HAVE YOU HAD OR DO YOU HAVE:	YES	NO
Endometriosis	☐	☐
Chronic Pelvic Pain	☐	☐
Abnormal Pap smear	☐	☐
Chronic urinary tract infections	☐	☐
Osteoporosis	☐	☐
Other:	☐	☐

LIST CURRENT MEDICATIONS, VITAMINS, HERBS

DRUG ALLERGIES/SENSITIVITES	
DRUG	REACTION

OTHER MEDICAL HISTORY: HAVE YOU HAD OR DO YOU HAVE:	YES	NO	COMMENTS
Breast Cancer	☐	☐	
Colon Cancer	☐	☐	
Ovarian Cancer	☐	☐	
Other Cancer	☐	☐	
Migraine Headache	☐	☐	
Stroke	☐	☐	
Multiple Sclerosis	☐	☐	
Seizures	☐	☐	
Glaucoma	☐	☐	
Hypertension	☐	☐	
Elevated cholesterol	☐	☐	
Heart Murmur	☐	☐	
Heart attack	☐	☐	
Blood clotting disorder	☐	☐	
Anemia	☐	☐	
Blood transfusion	☐	☐	
Asthma	☐	☐	
Thyroid problems	☐	☐	
Diabetes	☐	☐	
Emphysema	☐	☐	
Chronic bronchitis	☐	☐	
Ulcer	☐	☐	
Colitis/IBS	☐	☐	
Gallstones	☐	☐	
Liver disease	☐	☐	
Kidney disease	☐	☐	
Arthritis	☐	☐	
Autoimmune disorder	☐	☐	
Stress/Anxiety	☐	☐	
Depression	☐	☐	
Chemical dependency	☐	☐	

PREGNANCIES AND OUTCOMES

How many pregnancies have you had?		How many live births have you had?	
How many miscarriages have you had?		How many living children do you have?	

PAST SURGERIES OR PROCEDURES

DATE	PROCEDURE

HABITS	YES	NO	QUANT
Do you smoke?	☐	☐	
Do you consume alcohol?	☐	☐	
Do you exercise regularly?	☐	☐	
Type of exercise:			
Any major changes at home?	☐	☐	
Work description:			

MENSTRUAL HISTORY	
What is your current method of contraception?	
What is the first day of your last period?	
Typical # days of flow:	
Typical # days from 1st day of period to 1st day of next period:	
Menopause Symptoms?	☐ Yes ☐ No
Post Menopausal?	☐ Yes ☐ No
Month/Year of your last period:	

SAFETY

Discussed seatbelt use, helmet use, texting while driving, night lights, and firearms?	YES ☐	NO ☐	N/A ☐

FAMILY HISTORY

Is there a family history of:			Relationship of Family Member *(ex. Maternal grandmother, paternal aunt)*	Is this person Living	Deceased
Breast Cancer	☐ Yes	☐ No		☐	☐
Ovarian Cancer	☐ Yes	☐ No		☐	☐
Colon Cancer	☐ Yes	☐ No		☐	☐
Cervical Cancer	☐ Yes	☐ No		☐	☐
Uterine Cancer	☐ Yes	☐ No		☐	☐
Other Cancer	☐ Yes	☐ No		☐	☐
Osteoporosis	☐ Yes	☐ No		☐	☐
Hypertension	☐ Yes	☐ No		☐	☐
High Cholesterol	☐ Yes	☐ No		☐	☐
Heart Disease	☐ Yes	☐ No		☐	☐
Stroke	☐ Yes	☐ No		☐	☐
Blood Clots	☐ Yes	☐ No		☐	☐
Diabetes	☐ Yes	☐ No		☐	☐
Thyroid Disease	☐ Yes	☐ No		☐	☐
Autoimmune Disorders	☐ Yes	☐ No		☐	☐
Alcohol Abuse	☐ Yes	☐ No		☐	☐
Depression	☐ Yes	☐ No		☐	☐
Other mental illness	☐ Yes	☐ No		☐	☐
Other	☐ Yes	☐ No		☐	☐

ARE YOU EXPERIENCING ANY OF THE FOLLOWING? Please check all that apply

1	Weight Loss	☐	Weight gain	☐	Fever	☐	Fatigue	☐
2	Eye Problem	☐	Hearing Problem	☐				
3	Chest Pain	☐	Irregular Heartbeat	☐				
4	Wheezing	☐	Shortness of Breath	☐	Persistent Cough	☐		
5	Nausea/vomitting	☐	Diarrhea	☐	Bloody Stool	☐	Strain to have BM	☐
6	Abdominal pain	☐	Bloating/gas	☐				
7	Urinary Leakage	☐	Urinary Urgency	☐	Urinary Frequency	☐	Pain with urination	☐
8	Weak Stream	☐	Difficulty Voiding	☐	Incomplete Emptying	☐		
9	Blood in urine	☐	Bulge from vagina	☐				
10	Rash	☐	Bruises	☐				
11	Breast Lumps	☐	Breast Discharge	☐	Breast Pain	☐		
12	Depression	☐	Stress/Anxiety	☐	Moody	☐		
13	Painful Joints	☐	Muscle Weakness/pain	☐	Backache	☐		
14	Anemia	☐	Swollen Lymph Nodes	☐				
15	Sexually Active	☐	Not Sexually Active	☐	Bleeding with Intercourse	☐		
16	Vaginal dryness	☐	Loss of sexual drive	☐	Pain with Intercourse	☐		
17	Possible contact with:		Sexually Transmitted Disease	☐	Hepatitis	☐		

PATIENT SIGNATURE

Patient Signature	