BASELINE PATIENT HISTORY FOR UNDER AGE 50

Date: Name: DOB: Age:

HAVE YOU HAD OR DO YOU HAVE:	YES	NO
Endometriosis	☐	☐
Chronic Pelvic Pain	☐	☐
Pelvic Infections	☐	☐
Abnormal Pap smear	☐	☐
Infertility	☐	☐
Ovarian Cancer	☐	☐
Chronic urinary tract infections	☐	☐
Osteoporosis	☐	☐
Have you had HPV Vaccine 1, 2 & 3?	☐	☐
Other:		

ATTACH ADDITIONAL SHEET IF NOT ENOUGH SPACE

DRUG ALLERGIES/SENSITIVITIES

DRUG	REACTION

LIST CURRENT MEDICATIONS, VITAMINS, HERBS

OTHER MEDICAL HISTORY: HAVE YOU HAD OR DO YOU HAVE:	YES	NO	COMMENTS
Breast Cancer	☐	☐	
Colon 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	☐	☐	
Eating Disorder	☐	☐	
Chemical Dependency-please name	☐	☐	

PAST SURGERIES OR PROCEDURES

DATE	PROCEDURE

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?

DATE	VAGINAL	C-SECTION	MISCARRIAGE	Gestational Age	FEMALE	MALE	COMPLICATIONS
	☐	☐	☐		☐	☐	
	☐	☐	☐		☐	☐	
	☐	☐	☐		☐	☐	
	☐	☐	☐		☐	☐	
	☐	☐	☐		☐	☐	
	☐	☐	☐		☐	☐	
	☐	☐	☐		☐	☐	

HABITS	YES	NO	QUAN
Any major changes at home?	☐	☐	
Do you smoke?	☐	☐	
Do you consume alcohol?	☐	☐	
Do you use illegal drugs?	☐	☐	
Do you exercise regularly?	☐	☐	
Type of exercise			
Work description			

SAFETY	YES	NO	N/A
Do you wear a seatbelt every time you are in car?	☐	☐	☐
Do you abstain from text messaging while driving?	☐	☐	☐
Do you wear a helmet when cycling/skating?	☐	☐	☐
If you have guns in your home are they kept locked?	☐	☐	☐
Do you use a night light and keep floors open to prevent falls?	☐	☐	☐

MENSTRUAL HISTORY

What is the first day of your last period?			None	Mild	Mod	Severe
Typical # days of flow		Amount of Flow	☐	☐	☐	☐
Typical # days from 1st day of period to 1st day of next period		Cramps	☐	☐	☐	☐
Menopause Symptoms	☐ Yes ☐ No	PMS	☐	☐	☐	☐
Post Menopausal	☐ Yes ☐ No	Bleeding between periods	☐ Yes	☐ No		
Month/Year of your last period		What is your current method of contraception?				

FAMILY HISTORY

Is there a family history of:		Relationship of Family Member *(ex. Maternal grandmother, paternal aunt)*	Age when Diagnosed	Is this person Living	Deceased	Age
Breast Cancer	☐ Yes ☐ No			☐	☐	
Ovarian Cancer	☐ Yes ☐ No			☐	☐	
Colon 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			☐	☐	

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