

Name \_\_\_\_\_ Nick Name \_\_\_\_\_ Birthday \_\_\_\_\_

**GYNECOLOGY HISTORY**

Total Pregnancies \_\_\_\_\_ Live Births \_\_\_\_\_ Miscarriages/Terminations \_\_\_\_\_ Living Kids \_\_\_\_\_  
 Birth Control Using Now \_\_\_\_\_ In past \_\_\_\_\_  
 Practicing safe sex \_\_\_\_\_ Sexual Orientation \_\_\_\_\_ Regular Periods \_\_\_\_\_  
 Age Periods Began \_\_\_\_\_ Age Periods Ended \_\_\_\_\_ How often \_\_\_\_\_ How long last \_\_\_\_\_  
 Abnormally Heavy \_\_\_\_\_ Abnormally Painful \_\_\_\_\_ Bleed Between Periods \_\_\_\_\_ Bleed After Sex \_\_\_\_\_  
 History Abnormal Paps \_\_\_\_\_ When \_\_\_\_\_ Diagnosis \_\_\_\_\_ Treatment \_\_\_\_\_  
 Sexually Transmitted Diseases: HPV Warts Herpes Chlamydia Gonorrhea Hepatitis Syphilis HIV  
 Frequent Discharge \_\_\_\_\_ Describe (*itch, pain, odor, color, etc.*) \_\_\_\_\_  
 PMS \_\_\_\_\_ Describe What & When \_\_\_\_\_  
 Urinary Leakage \_\_\_\_\_ a problem? \_\_\_\_\_ w/cough/sneeze \_\_\_\_\_ urgency \_\_\_\_\_ wear pad \_\_\_\_\_  
 Sexual Problems: Pain \_\_\_\_\_ at outside \_\_\_\_\_ deep inside \_\_\_\_\_ no desire \_\_\_\_\_ no pleasure \_\_\_\_\_  
 Female Cancer History in Family \_\_\_\_\_ in Self \_\_\_\_\_  
 Other \_\_\_\_\_

**LIFE STYLE**

Who lives with you \_\_\_\_\_ Pets \_\_\_\_\_  
 Job Title \_\_\_\_\_ Job Description \_\_\_\_\_ Like Work? \_\_\_\_\_  
 Exercise \_\_\_\_\_ Type \_\_\_\_\_ Frequency \_\_\_\_\_  
 Multivitamin \_\_\_\_\_ Calcium/day \_\_\_\_\_ Vitamin D \_\_\_\_\_ Iron \_\_\_\_\_ Other \_\_\_\_\_  
 # meals/day \_\_\_\_\_ # veggie servings/day \_\_\_\_\_ amt caffeine/day \_\_\_\_\_ alcohol/day \_\_\_\_\_  
 Smoke \_\_\_\_\_ #/day \_\_\_\_\_ how long \_\_\_\_\_ tried to quit \_\_\_\_\_ want to quit \_\_\_\_\_  
 Prior Smoker \_\_\_\_\_ Quit When \_\_\_\_\_ Used What to Help \_\_\_\_\_  
 Using which street drugs now \_\_\_\_\_ Which ones Ever \_\_\_\_\_  
 Do Self Breast Exams \_\_\_\_\_ Sleep Well \_\_\_\_\_ Safe at Home \_\_\_\_\_  
 History of Physical or Sexual Abuse \_\_\_\_\_  
 Identify your stressors \_\_\_\_\_

**MEDICATIONS**

PRESCRIBED MEDICINE	DOSE	TIMES/ DAY	WHY	PRESCRIBER

OVER THE COUNTER	DOSE	HOW OFTEN	WHY

HERBALS	DOSE	HOW OFTEN	WHY

HOMEOPATHIC	DOSE	HOW OFTEN	WHY

**ALLERGIES**

Food \_\_\_\_\_ Reaction \_\_\_\_\_ Food \_\_\_\_\_ Reaction \_\_\_\_\_  
Food \_\_\_\_\_ Reaction \_\_\_\_\_ Food \_\_\_\_\_ Reaction \_\_\_\_\_  
Drug \_\_\_\_\_ Reaction \_\_\_\_\_ Drug \_\_\_\_\_ Reaction \_\_\_\_\_  
Drug \_\_\_\_\_ Reaction \_\_\_\_\_ Drug \_\_\_\_\_ Reaction \_\_\_\_\_  
Latex \_\_\_\_\_ Reaction \_\_\_\_\_ Tape/Adhesive \_\_\_\_\_  
Intolerances \_\_\_\_\_  
Inhalants \_\_\_\_\_

**SCREENING TESTS** (when was the last time you had one done?)

Physical \_\_\_\_\_ General Blood Work \_\_\_\_\_ Cholesterol \_\_\_\_\_  
Mammogram \_\_\_\_\_ Pap Smear \_\_\_\_\_ Colonoscopy \_\_\_\_\_  
Bone Density \_\_\_\_\_ Ultrasound \_\_\_\_\_ Other \_\_\_\_\_

**OTHER PROVIDERS**

Primary Care \_\_\_\_\_ Location \_\_\_\_\_ Send Results \_\_\_\_\_  
Surgeon \_\_\_\_\_ Specialist \_\_\_\_\_ Specialist \_\_\_\_\_  
Massage Therapist \_\_\_\_\_ Chiropractor \_\_\_\_\_ Acupuncturist \_\_\_\_\_  
Psychotherapist \_\_\_\_\_ Other \_\_\_\_\_ Other \_\_\_\_\_

**FAMILY HISTORY** (list their major diseases i.e. asthma, heart, diabetes, cancers, cholesterol, etc. etc)

Mother \_\_\_\_\_ Father \_\_\_\_\_  
Grandparents \_\_\_\_\_  
Siblings \_\_\_\_\_  
Children \_\_\_\_\_ Aunts/Uncles \_\_\_\_\_

**SURGICAL HISTORY**

Surgery \_\_\_\_\_ Year \_\_\_\_\_ Hospital \_\_\_\_\_  
Surgery \_\_\_\_\_ Year \_\_\_\_\_ Hospital \_\_\_\_\_  
Surgery \_\_\_\_\_ Year \_\_\_\_\_ Hospital \_\_\_\_\_  
Surgery \_\_\_\_\_ Year \_\_\_\_\_ Hospital \_\_\_\_\_  
Surgery \_\_\_\_\_ Year \_\_\_\_\_ Hospital \_\_\_\_\_

**MEDICAL HISTORY**

\_\_\_ Heart Disease \_\_\_ Hepatitis \_\_\_ Headache \_\_\_ Anxiety \_\_\_ Mono  
\_\_\_ Lung Disease \_\_\_ Hernia \_\_\_ Sinus Problem \_\_\_ Panic Attacks \_\_\_ Lyme Disease  
\_\_\_ Liver Disease \_\_\_ Asthma \_\_\_ Eye Problem \_\_\_ Depression \_\_\_ Fibromyalgia  
\_\_\_ Kidney Disease \_\_\_ Emphysema \_\_\_ Ear Problem \_\_\_ Suicide Attempt \_\_\_ Chronic Fatigue  
\_\_\_ Thyroid Disease \_\_\_ Ulcers / GERD \_\_\_ Mouth Problem \_\_\_ Trouble Sleeping \_\_\_ Arthritis  
\_\_\_ Diabetes \_\_\_ High Cholesterol \_\_\_ TMJ \_\_\_ Restless Leg \_\_\_ Carpal Tunnel  
\_\_\_ Seizures \_\_\_ Blood Disease \_\_\_ Neck Problem \_\_\_ Trauma \_\_\_ MRSA  
\_\_\_ Stroke \_\_\_ Cancer \_\_\_ Bone Disease \_\_\_ Skin Lesions \_\_\_ Eczema/ Psoriasis

Elaborate on above \_\_\_\_\_  
\_\_\_\_\_

Other \_\_\_\_\_

Any Questions? \_\_\_\_\_  
\_\_\_\_\_

*Thank you for taking your time to fully answer all questions. This helps me serve you better.*

\_\_\_\_\_ Dr. Terri Vanderlinde \_\_\_\_\_ Date