

BASELINE PATIENT HISTORY AGE 50 AND OLDER

Date:						Marital Status:	<input type="checkbox"/> M	<input type="checkbox"/> D	<input type="checkbox"/> S	<input type="checkbox"/> Partnered	<input type="checkbox"/> W
Name:				DOB:			Ethnicity:	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic		
Age:	If you would like to communicate with us via our Web Portal, provide your email address:										

HAVE YOU HAD OR DO YOU HAVE:	YES	NO	Race:	<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> Asian	<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Native American	<input type="checkbox"/> Other/Multiple
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Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Preferred Language:									
Chronic Pelvic Pain	<input type="checkbox"/>	<input type="checkbox"/>	OTHER MEDICAL HISTORY:			YES	NO	COMMENTS				
Abnormal Pap smear	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU HAD OR DO YOU HAVE:									
Chronic urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>	Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>							
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>							
Other:	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>							
			Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>							

LIST CURRENT MEDICATIONS, VITAMINS, HERBS	YES	NO	
	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headache
	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension
	<input type="checkbox"/>	<input type="checkbox"/>	Elevated cholesterol
	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack
	<input type="checkbox"/>	<input type="checkbox"/>	Blood clotting disorder
	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion
	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems
	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
	<input type="checkbox"/>	<input type="checkbox"/>	Chronic bronchitis
	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
	<input type="checkbox"/>	<input type="checkbox"/>	Colitis/IBS

DRUG ALLERGIES/SENSITIVITIES			YES	NO	
DRUG	REACTION				
		Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	
		Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	
		Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	
		Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
		Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	
		Stress/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
		Depression	<input type="checkbox"/>	<input type="checkbox"/>	
		Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	

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	MENSTRUAL HISTORY	
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>		What is your current method of contraception?	
Do you consume alcohol?	<input type="checkbox"/>	<input type="checkbox"/>		What is the first day of your last period?	
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>		Typical # days of flow:	
Type of exercise:				Typical # days from 1st day of period to 1st day of next period:	
Any major changes at home?	<input type="checkbox"/>	<input type="checkbox"/>		Menopause Symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work description:				Post Menopausal? <input type="checkbox"/> Yes <input type="checkbox"/> 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		Is this person	
	Yes	No	Living	Deceased
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Fever	<input type="checkbox"/> Fatigue	<input type="checkbox"/> None
<input type="checkbox"/> Eye Problem	<input type="checkbox"/> Hearing Problem			<input type="checkbox"/> None
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Irregular Heartbeat			<input type="checkbox"/> None
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Persistent Cough		<input type="checkbox"/> None
<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Bloody Stool	<input type="checkbox"/> Strain to have BM	<input type="checkbox"/> None
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Bloating/gas			<input type="checkbox"/> None
<input type="checkbox"/> Urinary Leakage	<input type="checkbox"/> Urinary Urgency	<input type="checkbox"/> Urinary Frequency	<input type="checkbox"/> Pain with urination	<input type="checkbox"/> None
<input type="checkbox"/> Incomplete Emptying	<input type="checkbox"/> Weak Stream	<input type="checkbox"/> Difficulty Voiding		<input type="checkbox"/> None
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Bulge from vagina			<input type="checkbox"/> None
<input type="checkbox"/> Rash	<input type="checkbox"/> Bruises			<input type="checkbox"/> None
<input type="checkbox"/> Breast Lumps	<input type="checkbox"/> Breast Discharge	<input type="checkbox"/> Breast Pain		<input type="checkbox"/> None
<input type="checkbox"/> Depression	<input type="checkbox"/> Stress/Anxiety	<input type="checkbox"/> Moody		<input type="checkbox"/> None
<input type="checkbox"/> Painful Joints	<input type="checkbox"/> Muscle Weakness/pain	<input type="checkbox"/> Backache		<input type="checkbox"/> None
<input type="checkbox"/> Anemia	<input type="checkbox"/> Swollen Lymph Nodes			<input type="checkbox"/> None
<input type="checkbox"/> Yes <input type="checkbox"/> No Sexually Active	<input type="checkbox"/> Pain with Intercourse	<input type="checkbox"/> Bleeding with Intercourse		<input type="checkbox"/> None
<input type="checkbox"/> Vaginal dryness	<input type="checkbox"/> Loss of sexual drive			<input type="checkbox"/> None
<input type="checkbox"/> Possible contact with	<input type="checkbox"/> HIV	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> None

PRIMARY CARE PHYSICIAN/PHARMACY INFORMATION

Name of Primary Care Physician:	
Address:	
City, State, Zip	
Phone number:	
Pharmacy Name:	
Pharmacy Address:	
Phone Number:	
Patient Signature	