

BASELINE PATIENT HISTORY FOR UNDER AGE 50

| | | | | | | | | |
|-------|--|-----------------|----------------------------|----------------------------|-----------------------------------|---------------------------------------|----------------------------|--|
| 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/Multipl |
|------------------------------|-----|----|-------|--------------------------------|--------------------------------|--------------------------------|---|--|--|

| | | | | | | | | | |
|------------------------------------|--------------------------|--------------------------|-------------------------------------|--|--------------------------|--------------------------|-----------------|--|--|
| Endometriosis | <input type="checkbox"/> | <input type="checkbox"/> | Preferred Language: | | | | | | |
| Chronic Pelvic Pain | <input type="checkbox"/> | <input type="checkbox"/> | OTHER MEDICAL HISTORY: | | YES | NO | COMMENTS | | |
| Pelvic Infections | <input type="checkbox"/> | <input type="checkbox"/> | HAVE YOU HAD OR DO YOU HAVE: | | | | | | |
| Abnormal Pap smear | <input type="checkbox"/> | <input type="checkbox"/> | Breast Cancer | | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Infertility | <input type="checkbox"/> | <input type="checkbox"/> | Colon Cancer | | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Ovarian Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Other Cancer | | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Chronic urinary tract infections | <input type="checkbox"/> | <input type="checkbox"/> | Migraine Headache | | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Have you had HPV Vaccine 1, 2 & 3? | <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis | | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Other: | | | Seizures | | <input type="checkbox"/> | <input type="checkbox"/> | | | |

ATTACH ADDITIONAL SHEET IF NOT ENOUGH SPACE

| PAST SURGERIES OR PROCEDURES | | |
|------------------------------|-------------------------|--------------------------|
| DATE | PROCEDURE | |
| | Hypertension | <input type="checkbox"/> |
| | Elevated cholesterol | <input type="checkbox"/> |
| | Heart Murmur | <input type="checkbox"/> |
| | Heart attack | <input type="checkbox"/> |
| | Blood clotting disorder | <input type="checkbox"/> |
| | Anemia | <input type="checkbox"/> |
| | Blood transfusion | <input type="checkbox"/> |
| | Asthma | <input type="checkbox"/> |

| LIST CURRENT MEDICATIONS, VITAMINS, HERBS | | |
|---|---------------------------------|--------------------------|
| DATE | PROCEDURE | |
| | Thyroid problems | <input type="checkbox"/> |
| | Diabetes | <input type="checkbox"/> |
| | Emphysema | <input type="checkbox"/> |
| | Chronic bronchitis | <input type="checkbox"/> |
| | Ulcer | <input type="checkbox"/> |
| | Colitis/IBS | <input type="checkbox"/> |
| | Gallstones | <input type="checkbox"/> |
| | Liver disease | <input type="checkbox"/> |
| | Kidney disease | <input type="checkbox"/> |
| | Arthritis | <input type="checkbox"/> |
| | Autoimmune disorder | <input type="checkbox"/> |
| | Stress/Anxiety | <input type="checkbox"/> |
| | Depression | <input type="checkbox"/> |
| | Eating Disorder | <input type="checkbox"/> |
| | Chemical Dependency-please name | <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? | | |

| DATE | VAGINAL | C-SECTION | MISCARRIAGE | Gestational Age | MALE | FEMALE | COMPLICATIONS |
|------|--------------------------|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|---------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

| HABITS | | | YES | NO | QUAN | SAFETY | | | |
|----------------------------|--------------------------|--------------------------|-----|----|------|---|--------------------------|--------------------------|--------------------------|
| Any major changes at home? | <input type="checkbox"/> | <input type="checkbox"/> | | | | Do you wear a seatbelt every time you are in car? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> | | | | Do you abstain from text messaging while driving? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you consume alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | | | | Do you wear a helmet when cycling/skating? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use illegal drugs? | <input type="checkbox"/> | <input type="checkbox"/> | | | | If you have guns in your home are they kept locked? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you exercise regularly? | <input type="checkbox"/> | <input type="checkbox"/> | | | | Do you use a night light and keep floors open to prevent falls? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Type of exercise | | | | | | | | | |
| Work description | | | | | | | | | |

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 | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Menopause Symptoms | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cramps | | | |
| Post Menopausal | <input type="checkbox"/> Yes <input type="checkbox"/> No | PMS | | | |
| Month/Year of your last period | | Bleeding between periods | | | |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | What is your current method of contraception? | | | |

FAMILY HISTORY

| Is there a family history of: | Relationship of Family Member | | Age when Diagnosed | Is this person | | Age |
|-------------------------------|--|-----------------------------|--------------------|--------------------------|--------------------------|-----|
| | <i>(ex. Maternal grandmother, paternal aunt)</i> | | | Living | Deceased | |
| Breast Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Ovarian Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Colon Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Other Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Osteoporosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hypertension | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> | <input type="checkbox"/> | |
| High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Blood Clots | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Thyroid Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Autoimmune Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Alcohol Abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Other mental illness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <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/vomitting | <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"/> Difficulty Voiding | <input type="checkbox"/> Weak Stream | | <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"/> Bleeding with Intercourse | <input type="checkbox"/> Pain 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 Dis | <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 | |