

ESTABLISHED / ANNUAL INFORMATION FORM

NAME _____ DOB ____ / ____ / ____ AGE _____ DATE _____

Local Pharmacy Name: _____ Phone: _____

Mail Order Pharmacy: _____ Phone: _____

Any specific problems or issues you would like to address: _____

List any changes in your Medical or Surgical history since your last visit: _____

ALLERGIES:

Drug: _____

Food: _____

Latex Allergy: Yes _____ No _____

SOCIAL HISTORY:

Are you currently a victim of domestic violence? _____ Yes _____ No _____ Physical _____ Sexual _____ Emotional

Have you ever been a victim of sexual abuse or assault _____ Yes _____ No

Do you exercise regularly? _____ Yes _____ No

Use of alcohol: _____ Yes _____ No Is this a change in use? _____ Yes _____ No

Use of tobacco: _____ Yes _____ No Former tobacco? _____ Yes _____ No

Use of recreational drugs? _____ Yes _____ No If currently, what? _____

Vaping: _____ Yes _____ No

FAMILY HISTORY:

Any Significant changes in your family history since your last visit? (Cancers, major medical problems)

Primary Care Physician: _____ Phone: _____

Address: _____ Fax: _____

PATIENT NAME: _____

AGE: _____

___ Single ___ Engaged ___ Married ___ Life partner ___ Separated ___ Divorced ___ Widow

GYNECOLOGIC HISTORY:

If you have periods:

First day of last menstrual period ____/____/____

Have your periods changed? YES/NO

How? _____

days between periods? _____

periods normally last? _____

Cramps with periods? YES/NO

Spotting between periods? YES/NO

Flow of cycle: LIGHT/MEDIUM/HEAVY Clots: YES/NO

Sexual History:

Are you currently sexually active: YES/NO

Sexual orientation: ___ Straight ___ Gay ___ Lesbian ___ Bisexual

Gender Identity: ___ Woman ___ Man ___ Transgender

Number of new sexual partners since last visit _____

Gender of sexual partners: M _____ and/or F _____

Number of HPV injections: ___ none ___ 1 ___ 2 ___ 3

What are you doing to prevent pregnancy?

Birth control pill _____, Condoms _____, IUD _____,

Nexplanon, _____, Vasectomy _____, Tubal ligation _____,

Abstinence _____, Menopause _____,

other (please explain) _____

SCREENINGS/TESTS:

Last Pap smear ____/____/____

Results: _____

Colonoscopy ____/____/____

Results: _____

Bone Density ____/____/____

Results: _____

Mammogram ____/____/____

Results: _____

Family History of Breast Cancer: Yes or No Whom _____

Office use only*

Vital Signs: HT _____ WT _____ BP _____/_____

G _____ P _____

LMP _____

BMI: _____

SMOKER: Current / Previous / Never | VAPING: Yes or No

STD: _____
Need refills: _____