ESTABLISHED / ANNUAL INFORMATION FORM

NAME ____ **DOB** _____/_____/_____ **AGE** ________**DATE** _____________

Race: African American/Black_____, American Indian/Alaskan Native _____, Asian _____, Caucasian/White _____, Pacific Islander/Native Hawaiian _____, Other _____, Declined _____

Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____

Sexual Orientation: Straight or Heterosexual ____ Bisexual ____ Lesbian, Gay, or Homosexual, ____ Other____

Gender Identity: Female ____ Male ____ Genderqueer, neither male or female exclusively ____
Transgender female/Trans women/Male to female ____ Transgender male/Trans man/Female to male ____

Local Pharmacy Name: _____________________________________ **Phone:** _________________________________

Mail Order Pharmacy: _____________________________________ **Phone:** __________________________________

REASON FOR TODAY'S VISIT: ____

MEDICAL HISTORY: (List new illnesses ***SINCE YOUR LAST VISIT***) ____
____

SURGICAL / ACCIDENTS / HOSPITALIZATIONS: (List operations, serious accidents, and hospitalizations ***SINCE YOUR LAST VISIT***
____

OBSTETRICAL HISTORY: (List all pregnancies ***SINCE YOUR LAST VISIT***) ____
____

ALLERGIES:
Drug: ____
Food: ____
Latex Allergy: **Yes** _____ **No** _____

Date of last flu shot: _________________
If age 65 years, date of Pneumonia Vaccine: _____________________

SOCIAL HISTORY:
Are you currently a victim of domestic violence? _____ Yes _____ No _____ Physical _____ Sexual
Do you exercise regularly? _____ Yes _____ No
Use of alcohol: _____ Yes _____ No is this a change in use? _____ Yes _____ No
Two or more times in the past 12 months had four or more alcoholic beverages in one day? _____Yes _____ No
Use of tobacco: _____ Yes _____ No is this a change in use? _____ Yes _____ No
Use of recreational drugs? _____ Yes _____ No ____ previously quit _____Currently/what? _________

FAMILY HISTORY:

List any 1st **DEGREE** relatives (mother/father/grandparents/siblings/children) diagnosed with or deceased from any illnesses ***SINCE YOUR LAST VISIT***:
____

Primary Care Physician: ____
Other Care Providers: *(please specify specialty)* ____

ESTABLISHED / ANNUAL INFORMATION FORM **ROOM # _____________**

PATIENT NAME: ____ **AGE: ____________________**

____ Single ____ Engaged ____ Married _____ Life partner ____ Lesbian ____Separated ____ Divorced _____Widow

GYNECOLOGIC HISTORY:

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*

Are you currently sexually active: *YES/NO*
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 _____, Diaphragm _____, Vasectomy______, tubal ligation _____, 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____

MEDICATIONS: (List all ***CURRENT*** medications, vitamins, and herbal supplements you are taking) ___________________________________
____

REVIEW OF SYSTEMS:

CONST: Fatigue, body aches, weight loss, weight gain, fever, chills, night sweats	**CARDIO**: Chest pains, rapid or irregular heart beats
EYES: Impaired vision	**RESP**: Shortness of breath, cough
HENT: Headaches	**NEURO**: Muscular weakness, tingling or numbness
BREASTS: Lumps, swelling, tenderness, nipple discharge	**MUSC**: Joint pain, muscle pain
GI: Nausea, vomiting, diarrhea, constipation, abdominal pain, blood in stools, loss of appetite, hemorrhoids	**ENDO**: Heat or cold intolerance, excessive thirst
GU: Urgent or frequent urination, blood in urine, painful intercourse, vaginal discharge, genital sores, incontinence	**PSYCH**: Anxiety, depression, difficulty sleeping
INTEGUMENT: Rash, new or growing moles, excessive hair growth	**HEME/LYMPH**: Easy bruising, easy bleeding

Office use only*

Vital Signs: **HT** ________ **WT** ________ **BP** ________/_________ **G**________ **P**________

LMP ______________ **BMI**:_________

S/A _____________________ **Cramps w menses** ______________________

SMOKER: Current / Previous / Never

U/A Reference:

Neg Neg Neg 10001-1.035 Neg 4.6-8.0 Neg Normally present up to 1.0 mg/dl Neg Neg

IFOB: _______

HPV: _______

STD: _______

LDM: ______

ERX: _______

M/O: _______