

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_  
Race: \_\_\_\_\_ Religion: \_\_\_\_\_  
Referred by: \_\_\_\_\_ Allergies: \_\_\_\_\_

**MEDICAL HISTORY:** Please list any conditions currently being treated and name of treating physician:

Past Illnesses: \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

**GYNECOLOGICAL HISTORY:**

Age of First Menstrual Period: \_\_\_\_\_ Have you ever had an abnormal Pap? YES NO  
Frequency of Periods: \_\_\_\_\_ If YES, how was it treated? \_\_\_\_\_  
Are you sexually active? \_\_\_\_\_ Method of Contraception: \_\_\_\_\_  
Any problems with incontinence? \_\_\_\_\_ Any history of sexually transmitted diseases? \_\_\_\_\_  
(explain) \_\_\_\_\_ (such as herpes, gonorrhea, chlamydia, syphilis)

**OBSTETRICAL HISTORY:**

Date	# Weeks	C-Section or Vaginal Delivery	Birth Weight	List any complications

Any history of miscarriage(s): \_\_\_\_\_ Any history of abortion(s): \_\_\_\_\_

**FAMILY HISTORY:** Mother: Living/Deceased Age: \_\_\_\_\_ If deceased, cause of death: \_\_\_\_\_  
Father: Living/Deceased Age: \_\_\_\_\_ If deceased, cause of death: \_\_\_\_\_

Sibling history: \_\_\_\_\_

Please list any family illnesses (such as diabetes, cancer, arthritis, heart disease) and briefly explain:

**SOCIAL HISTORY:**

OCCUPATION: \_\_\_\_\_

Do you smoke? YES NO, if yes, how much? \_\_\_\_\_ pack(s) per \_\_\_\_\_ Would you like to quit? YES NO  
Do you drink alcohol? YES NO, how much? \_\_\_\_\_ Are you concerned about your drinking YES NO  
Do you use "street" drugs? YES NO \_\_\_\_\_ Do you exercise? YES NO Type: \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Have you had any of the following problems within the past year?

	YES	NO	If yes to any of the following, please explain below:
General	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Ears, Nose, Throat, Mouth	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Psychological	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Hematologic/Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	
Allergic	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	

Please list any topics you would like to discuss with your doctor: \_\_\_\_\_

Date:	Review Date:	Review Date:	Review Date:	Review Date:
Dr: _____	Dr: _____	Dr: _____	Dr: _____	Dr: _____

I, \_\_\_\_\_ give Mile High OB/GYN permission to leave voice messages as follows:

Voice Message at Home: ☐ Yes ☐ No Phone Number: \_\_\_\_\_  
Voice Message at Work: ☐ Yes ☐ No Phone Number: \_\_\_\_\_  
Voice Message at Cell: ☐ Yes ☐ No Phone Number: \_\_\_\_\_

Please check what kind of voice message you would like us to leave:

☐ I would like your office to leave a **DETAILED** explanation of results and further instructions.

**OR**

☐ I would like your office to leave a message asking me to call the office back.

**PREFERRED PHARMACY:**

**Pharmacy Name:** \_\_\_\_\_ **Pharmacy #:** \_\_\_\_\_ **OR**

Cross Streets \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_