MEDICAL PROFILE

Today's Date:_____

Name:_____ Date of Birth:_____

Local Pharmacy (Name and Location):_____

Mail Order Pharmacy:_____

Allergies (Food, Drugs, Environmental)

[ ] NONE [ ] Latex [ ] Iodine

Allergy	Interaction

Current Medications

[ ] NONE

Prescription and non-prescription medicine, home remedies, birth control pills, herbs:

Medication Dosage

If space is not sufficient, please attach a copy of medications to this form.

Menstrual History

Date of you last menstrual period?_____

Age at first period: _____ If menopausal, age of menopause: _____

How often do you get your menstrual cycle?
Every _____ days, lasting _____ days

Are your cycles? [ ] Regular [ ] Irregular

Are you sexual active? [ ] Never [ ] Not currently [ ] Yes

Method of Contraceptive

Check all that apply.

[ ] Pregnant
[ ] None
[ ] Pill
[ ] Vasectomy
[ ] Condoms
[ ] Patch
[ ] Rhythm Method
[ ] NuvaRing
[ ] Depo Provera
[ ] Implant
[ ] IUD
[ ] Tubal Ligation
[ ] Essure
[ ] Seeking Pregnancy

Preventative Care

Did you receive the Gardsil Vaccine for HPV? [ ] Yes [ ] No If yes, did you receive all 3 doses? [ ] Yes [ ] No

Have you ever had a mammogram? [ ] Yes [ ] No If yes, when? _____ [ ] Normal [ ] Abnormal

Have you ever had a colonoscopy? [ ] Yes [ ] No If yes, when? _____ [ ] Normal [ ] Abnormal

Have you ever had a DEXA/Bone Density Scan? [ ] Yes [ ] No If yes, when? _____ [ ] Normal [ ] Abnormal

Obstetrics

Total Number of: Pregnancies: _____ Full Term Births: _____ Pre-Term Births: _____

Living Children: _____ Abortions Induced: _____ Miscarriages: _____

No.	Birth Date	# Weeks at Delivery	Sex	Birth Weight	Delivery Type	Complications	Location of Delivery
1							
2							
3							
4							
5							
6							
7							
8							

Social History

Do you use tobacco? [ ] Yes [ ] No If yes, [ ] Current Every Day, _____ Per Day
[ ] Current Some Days, Describe: _____
[ ] Former [ ] Never

Do you drink alcohol? [ ] Yes [ ] No If yes, [ ] Social Drinker [ ] Daily If yes, how many per week? _____

Do you use recreational drugs? [ ] Yes [ ] No If yes, what kind? _____