

Name: _____
 Birth Date, Age: _____
 Birthplace: _____
 Occupation: _____
 Marital Status: S M DP D W SEP
 Pharmacy (name, number & address): _____

Date: _____
 Home: _____ Cell: _____
 Race / Ethnicity Caucasian Black Asian
 Hispanic/Latino Other Refused

Please List Any Major Medical Illnesses:

1. _____
2. _____
3. _____

Please List All Current Medications:

1. _____
2. _____
3. _____

Please List All Past Surgeries: (What, When)

1. _____
2. _____
3. _____

Allergies:

Cigarettes current previous never / _____ packs per day
Alcohol: _____ drinks per week
Drug Use: _____

Please Indicate if you have completed the Gardasil series.

- I have not received the Gardasil vaccine.
 I have received the Gardasil vaccine. **Please Circle** dose 1 dose 2 dose 3

Menstrual History

Age at Onset: _____
 Cycle Length: _____
 Duration of Flow: _____
 Regular: YES NO
 Pain / Cramps: YES NO
 1st Day of Last Period _____
 Current Birth Control Method: _____

Pregnancy History

Never Been Pregnant
 Have Been Pregnant (List All Pregnancies)

Year	Delivery, Miscarriage or Abortion	Sex	Weight	Complications
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Past Medical History

	Y	N		Y	N		Y	N
Abnormal Pap Smear	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>
Genital Warts (HPV)	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer / Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection / Stones	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Urine with Cough	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic Inflammatory Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease / Attack	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Migraines / Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Uterine Anomaly	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
D.E.S. Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis / Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots in Legs/Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Hands / Feet	<input type="checkbox"/>	<input type="checkbox"/>	Major Accident	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	History of Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	Anesthetic Complications	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever / Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	Von Willebrand's/Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>

Family History

	Age	Overall Health	Age	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Sibling 1	_____	_____	_____	_____
Sibling 2	_____	_____	_____	_____
Sibling 3	_____	_____	_____	_____
Sibling 4	_____	_____	_____	_____
Partner	_____	_____	_____	_____
Child 1	_____	_____	_____	_____
Child 2	_____	_____	_____	_____
Child 3	_____	_____	_____	_____
Child 4	_____	_____	_____	_____

Please circle then list which relative has had any of the following:

- Breast Cancer _____
- Ovarian Cancer _____
- Uterine Cancer _____
- Other Cancer _____
- Diabetes _____
- Heart Trouble _____
- Stroke _____
- Epilepsy/Convulsion _____
- Tuberculosis _____
- Hepatitis _____
- Mental Illness _____
- Osteoporosis _____