Downtown:
836 Prudential Dr, Suite 1600
Jacksonville, FL 32207

Phone number: 904-399-4862
Fax Press: 904-402-8948

Name:_____**D.O.B.**_____**today's date**_____
Referred by:_____**Occupation:**_____
Reason for visit: Well-Woman screening ***or*** Problem:_____

Do you have any medication allergies? If yes- list below

Drug	Reaction	Drug	Reaction

Are you allergic to Latex? No/ Yes Reaction:_____
Are you allergic to iodine? No/ Yes Reaction:_____
Are you allergic to IV contrast No/ Yes Reaction:_____

List all medicines you take- Include over-the-counter, and herbal/ dietary supplements

Drug	Dose	How often?	Drug	Dose	How often

Pharmacy name, address, phone:_____

Menstrual History:
1st day of last period:_____ Age at onset:_____ Regular? Yes/ No
Flow: light / mod / heavy Cycle length start to start:_____ # days of bleeding:____
Postmenopausal? Yes/ No Year of Last period_____

Do you currently have?
__Pelvic pain
__Bleeding between periods
__Bleeding after intercourse
__Vaginal discharge
__Vaginal irritation
__Leaking of urine
__Other_____
__Night sweats/ hot flashes
__Pain with periods
__Pain with intercourse
__Bleeding after menopause

Medical History: Do YOU have any of the following?

__Heart disease
__Heart Murmur/ MVP
__High Blood Pressure
__High Cholesterol
__Stroke
__Migraine headaches
__Depression
__Anxiety
__Bleeding disorder
__Deep venous clot
__Pulmonary embolus
__Anemia
__Thyroid disease
__Osteoporosis
__Diabetes
__Kidney problems
__Reflux/ IBS/ Ulcer
__Hemorrhoids
__Colitis/ Crohns
__Hepatitis
__Seizures
__Breast problems
__Abnormal Pap
__Fibroids
__Endometriosis
__Infertility
__Polycystic Ovarian Synd
__STD
__HIV+/ AIDS
__Cancer:
__Other:_____
_____

Have you ever had a blood transfusion? No / Yes When?_____
Are you willing to have a blood transfusion to save your life? No/ Yes

List any surgeries

Date	Surgery

Pregnancy History

# of pregnancies:_____# births:_____# miscarriages:_____# abortions_____# children_____

Date/ Year	Baby's sex	Birth weight	Term/ preterm	Vaginal/C-sec.	Complications?

Family history: (Include mother/father/ grandparents/ aunts/ uncles/ siblings/ children)

	Whom?		Whom?		Whom?
High blood pressure		Birth Defect		Breast Cancer	
High cholesterol		Thyroid disorder		Ovarian Cancer	
Heart disease		Osteoporosis		Uterine Cancer	
Stroke		Alzheimer's		Colon Cancer	
Diabetes				Melanoma	
Blood Clots				Other Cancer	

Do you drink alcohol? Never / Occasionally / Daily
Any past or current tobacco use? Never/ Past/ Current **How much?**_____
Any past or current drug use? Never/ Past/ Current **What kind?**_____
Special Diet (circle) Diabetic/ Vegetarian/ Weight Watchers/ Atkins/ Other:_____
Type/ Amount of exercise:_____
Marital History: Single/Married/ Separated/Divorced/ Widowed
Living situation: alone/ with spouse or partner/ with parents or custodian/ other
Currently sexually active? Yes/ No **With opposite sex** or **With Same sex**
Have you had a new partner in the last 6 months? Yes/ No
Current birth control method: None/ Pill / Patch/ Ring/ injection/ IUD/ tubal ligation/ partner has vasectomy/ condoms/ abstinence/ hysterectomy/ Natural Family planning/
Do you use condoms? Never/ rarely/ most of the time/ always
Any current or past abuse or domestic violence? No/ Yes _____

Health Screening: (give date)
Last Pap Smear:_____
Last Mammogram:_____
Last Bone Density:_____
Last Colonoscopy:_____
Last Cholesterol screen:_____
HIV testing:_____

Vaccine history: (give date)
Last Flu vaccine:_____
Last Tetanus/ Pertussis:_____
Hepatitis B Series:_____
Gardisil or Cervarix series:_____
Pneumovax:_____