Downtown:
836 Prudential Dr, Suite 1202
Jacksonville, FL 32207

Mandarin:
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Jacksonville, FL 32223

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

Medical History: Do YOU have any of the following?

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

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: (mother, father, maternal or paternal 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
Sexually Active? Yes/ No **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:_____