Date:__________ Pharmacy Name:__________ Pharmacy Phone #:__________

Name:__________ Date of Birth:__________ Age:__________

Referring Provider: __________ Primary Care Physician:__________

Reason for Visit:__________ Cell #:__________

MEDICATIONS

List all medications & vitamins. Check here if none__________

Medication	Dose

ALLERGIES

List all allergies. Check here if none__________

Allergies	Reaction

SURGICAL HISTORY

Have you ever had any of the following **(circle Y or N)**

Appendectomy (removal of appendix)	Y / N	
Bladder Surgery	Y / N	
Breast Biopsy	Y / N	
Breast Implants / Reduction	Y / N	
Cesarean Section	Y / N	
Cholecystectomy (gallbladder removal)	Y / N	
Dilation & Curettage	Y / N	
Ectopic Pregnancy (tubal pregnancy)	Y / N	
Endometrial Ablation	Y / N	
Heart/Vascular	Y / N	
Hip	Y / N	
Hysterectomy	Y / N	
If YES what type of hysterectomy	Y / N	
Abdominal	Y / N	
Laparoscopic	Y / N	
Vaginal	Y / N	
Is your cervix still present?	Y / N	
Were your ovaries removed?	Y / N	
Hysteroscopy (viewing of uterus)	Y / N	
Knee	Y / N	
Laparoscopy	Y / N	
Colposcopy (viewing of the cervix)	Y / N	
LEEP/CKC	Y / N	
Mastectomy (removal of breasts)	Y / N	
Myomectomy (removal of fibroids)	Y / N	
Ovarian Cystectomy (removal of cysts)	Y / N	
Rectal	Y / N	
Shoulder	Y / N	
Tonsillectomy (removal of tonsils)	Y / N	
Tubal ligation ("tubes tied")	Y / N	
Other:	Y / N	

MEDICAL HISTORY

Have you ever had any of the following **(circle Y or N)**

Uterine fibroids	Y / N
Endometriosis	Y / N
Infertility	Y / N
Polycystic ovarian syndrome	Y / N
Pelvic inflammatory disease	Y / N
Breast problem	Y / N
Breast Cancer	Y / N
Cervical cancer	Y / N
Uterine cancer	Y / N
Ovarian cancer	Y / N
Anemia	Y / N
Anesthesia complications	Y / N
Anxiety disorder	Y / N
Arthritis	Y / N
Asthma	Y / N
Birth Defect/Inherited disease	Y / N
Cancer	Y / N
Clotting disorder	Y / N
Deep vein thrombosis	Y / N
Depression	Y / N
Diabetes	Y / N
Gastrointestinal problems	Y / N
Headaches or migraines	Y / N
Heart conditions	Y / N
Hepatitis	Y / N
High blood pressure	Y / N
Kidney or bladder problems	Y / N
Lung disease	Y / N
Psychiatric illness	Y / N
Pulmonary embolus	Y / N
Thyroid problems	Y / N
Other:	Y / N

ARIZONA SPECIALIZED GYNECOLOGY

Name:____ Date:__________________

SOCIAL HISTORY

Occupation:	
Will you accept blood transfusions?	Y / N
Sexually active?	Y / N
Marital status: ☐ S ☐ M ☐ D ☐ W	
Sexual orientation ☐ Heterosexual ☐ Homosexual	
Do you or have you ever smoked? Number of packs/day	Y / N
Alcohol intake	Y / N
How many glasses/day	
Street drugs:	Y / N
Which ones:	
☐ Exercise ☐ Never ☐ Sometimes ☐ Frequently ☐ All the time	

FAMILY HISTORY

Does any family member have any of the following?
(mother, father, sibling, child, grandfather, grandmother, aunt, uncle)

	(Circle Y or N)	Relation/Maternal or Paternal
Anemia	Y / N	M / P
Bleeding Disorder	Y / N	M / P
Breast Cancer	Y / N	M / P
Colon Cancer	Y / N	M / P
Diabetes	Y / N	M / P
Endometrial Cancer	Y / N	M / P
Heart problem	Y / N	M / P
Hypertension	Y / N	M / P
Osteoporosis	Y / N	M / P
Ovarian Cancer	Y / N	M / P
Stroke	Y / N	M / P
Uterine Cancer	Y / N	M / P
Pancreatic Cancer	Y / N	M / P
Other:	Y / N	M / P

GYNECOLOGY HISTORY

Date of last menstrual period	
Age at first period	
Age at menopause if postmenopausal	
Current birth control method	
Other contraception methods used in the past	
History of STD	Y / N
If yes, diagnosis:	
Date of last Pap Smear	
Have you ever had an abnormal PAP?	Y / N
If yes, when and diagnosis:	
Treatment	
Date of last Mammogram	
Date of last Bone Density Scan	
Date of last Colonoscopy	

OBSTETRIC HISTORY

Total Number of Pregnancies	
Number of Full Term Deliveries	
Number of Preterm Deliveries	
Number of Abortions	
Number of Miscarriages	
Number of Ectopic Pregnancies	
Birth Weight of Largest Infant	
Number of C-sections	
Number of Vaginal Deliveries	

Please **CIRCLE** all that apply: If you have none of the symptoms describing what the topic is, then select NO.

Constitutional: No Constitutional Symptoms; Fever Fatigue Significant Weight Gain/ Loss
Other____

Cardiovascular: No Cardiovascular Symptoms; Chest Pain Palpitations Shortness of Breath Swelling
Other____

Gastrointestinal: No Gastrointestinal Symptoms; Heartburn Indigestion Difficulty Swallowing Nausea Vomiting
Abdominal Pain Bowel Movement Changes
Other____

Genitourinary: No Genitourinary Symptoms; Blood in Urine Abnormal Bleeding Back Pain Trouble Urinating
Urinary Frequency Urinary Urgency Painful Urination Incontinence Rash Lesion
Discharge Vaginal Odor Vaginal Itching
Other____

Endocrine: No Endocrines Symptoms; Increased Hunger Increased Thirst
Other____

Menstrual Cycle: No Menstrual Symptoms; Mood Swings Irritability Tension/Anxiety Depressed Mood
Breast Pain/ Tenderness Bloating Feeling out of Control/Overwhelmed
Other____

Menopausal: No Menopausal Symptoms; Hot Flashes Night Sweats Vaginal Dryness Impaired Memory
Impaired Concentration
Other____

Sexual: No Sexual Problems; Decreased Sex Drive Orgasmic Dysfunction Pain with Sex
Other____

Psychiatric: No Psychiatric Problems; Depression Anxiety
Other____