



NAME: _____ Birth date: _____
 Preferred Pharmacy: _____

PROBLEMS YOU WISH TO DISCUSS WITH THE DOCTOR

1.
2.
3.
4.
5.

ALLERGIES TO MEDICATIONS

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CURRENT MEDICATIONS AND DOSAGE

Medications prescribed by Rosemark

Medications Prescribed by other providers

1.
2.
3.
4.

1.
2.
3.
4.

PREVIOUS SURGERIES

Date	Type of surgery	Date	Type of surgery
1.		4.	
2.		5.	
3.		6.	

PREGNANCIES (include miscarriages, abortions, or tubal pregnancies)

Date of Birth	Baby Weight	Vaginal/ Forceps/ C-sections	Boy or Girl	Complications

PAST MEDICAL HISTORY –List current problems, past diagnosis, and other hospitalizations

1.	4.	7.
2.	5.	8.
3.	6.	9.

(Example: Diabetes, Depression, Stroke, Anemia, Herpes, High Blood Pressure, Asthma ect.)

REPRODUCTIVE HISTORY

Age of first menses _____ Date of last period _____
 Date last Pap smear _____ Date last mammogram _____
 Date last colonoscopy _____ Date of last Bone Density Scan _____

Have you ever had an abnormal pap smear? Yes No

SEXUAL HISTORY

Sexual Preference (please circle) Heterosexual Homosexual Bi-Sexual
 Marital Status: _____ Do you have a new partner? Yes No
 Number of lifetime partners _____ Age of first sexual intercourse _____

Are you using any method to prevent pregnancy? No _____ Yes _____
 If YES which type (Please circle): Pill Tubal Vasectomy Condoms Depo-Provera
 IUD Diaphragm Rhythm Other _____

Do you have pain with intercourse? Yes No
 Are you suffering from low libido (sex drive)? Yes No

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

Uncontrollable loss of urine when you cough or sneeze _____
 Sensation of female organs dropping into the birth canal _____
 Sensation of stool bulging into the birth canal when having a bowel movement _____
 Do you smoke? No _____ Yes _____ cigarettes/day _____
 Do you drink? No _____ Yes _____ how much _____

FAMILY HISTORY

	Yes	No	Which Relative (Maternal/Paternal)		Yes	No	Which Relative
Breast cancer				Heart disease			
Colon Cancer				High blood pressure			
Ovarian cancer				Kidney disease			
Diabetes				Blood Clotting disorders			

Other _____

How did you hear about us? Family/Friend Radio TV Website Print Other: _____