

Marsha Brooks-Candela, M.D.

Christine Canela, M.D.

Alicia Costantino, M.D.

Patient Name: _____ DOB: _____ Age: _____ Race: _____

Occupation: _____ Referring Physician: _____

Reason for visit: _____ Date: _____

MEDICATION ALLERGY/SENSITIVITY

List all medication allergies and types of reactions: **None**

MEDICAL HISTORY (Check appropriate boxes)

- | | You | Family |
|---|--------------------------|--------------------------|
| 1. High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Asthma/Lung Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Thyroid Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Headaches/Migraines | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Nervous Disorder or Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Stomach, Bowel, or Gallbladder Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Kidney or Bladder Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. AIDS (HIV) | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Hepatitis (Type: _____) | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Anemia or Blood Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Blood Transfusion | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Breast Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Fertility | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Female or Sexual Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Chlamydia, Gonorrhea, or Herpes | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Syphilis | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Birth Defects or Inherited Diseases | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Sexual Abuse or Domestic Violence | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Other Medical Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. No Known Medical Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Immunizations up-to-date | <input type="checkbox"/> | <input type="checkbox"/> |

28. Last Pap Smear _____

29. History of abnormal Pap Smears?

If yes, when and where treated: _____

30. Last mammogram? (Date/Place) _____

31. History of abnormal mammogram readings?

SUBSTANCE USE (Circle only those used)

32. Alcohol: Type: _____ Amt: _____
33. Tobacco: Type: _____ Amt: _____

CURRENT MEDICATIONS BEING TAKEN & DOSAGES

HOSPITALIZATIONS List operations/serious illnesses that have required hospitalization. If more than four check this box

Month/Year	Illness or Operation	Complications	
		Yes	No
/		<input type="checkbox"/>	<input type="checkbox"/>
/		<input type="checkbox"/>	<input type="checkbox"/>
/		<input type="checkbox"/>	<input type="checkbox"/>
/		<input type="checkbox"/>	<input type="checkbox"/>

MENSTRUAL HISTORY

LMP: ____/____/____
 Menarche _____
 Interval _____
 Length of Period _____
Abnormalities:
 Excessive Bleeding _____
 Discharge _____
 Pain _____
 None _____

CONTRACEPTIVE HISTORY

Current Past
 Oral Contraceptives
 Type(s):
 IUD
 Diaphragm
 Norplant
 Sponge
 Spermicide
 Depo-Provera
 Condoms
 Sterilization
 Other _____

SEXUAL HISTORY

Sexually Active **Y / N**
 Age First Intercourse _____

# of Births	DOB MM/YY	Sex	Type of Delivery	Weight At birth	Complications	
					Yes (list)	No
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

34. Street Drugs: Type: _____ Amt: _____

Number of Pregnancies: _____
 Number of Miscarriages: _____
 Number of Abortions: _____