



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: \_\_\_\_\_