[NP PM ENG]

In accordance with HIPAA privacy requirements, please complete this from and hand it to the nurse when called back – Thank You!

Name:_____**DOB**_____
Height: _____ feet _____ inches

Reason for your visit today: _____

1-**Medications:** (including from other physicians, antibiotics, and supplements)
_____
_____
_____
_____

2-Drug Allergies (including Latex)
_____
_____
_____

3-Reproductive History:

- Are you currently menopausal? Yes
- How old were you when you got your last period_____ yr. old
- If not menopausal, what was the FIRST day of your last menstrual period? ____/____/____
- How many times have you been pregnant? (Including miscarriages or terminations) _____
- How many were delivered full term? (36-40 weeks) _____
- How many terminations? _____ How many miscarriages? _____
- How many were ectopic pregnancies? _____
- How many multiple pregnancies (ex:1 pregnancy with twins)? _____
- How many are living? _____

4-Date of last Colonoscopy: _____ Normal? Yes
5-Date of last Dexa Scan:_____ Normal? Yes
6-Date of last Mammogram: _____ Normal? Yes
7-Date of last Pap test: _____ Normal? Yes

8-Have you ever used tobacco products? No
If yes, do you currently use them? No
How many tobacco products a day do you use?_____