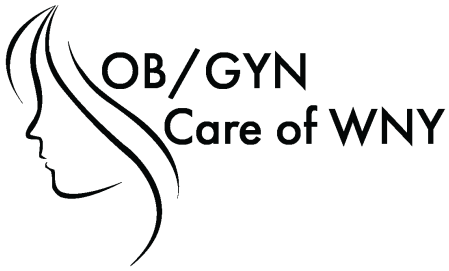

Annual/ New Patient History

Name:_____ DOB: _____

Pharmacy:_____ Pharmacy #:_____ PCP:_____

Chief Complaint:_____

Medications: _____

Allergies: _____

Vitals: Weight_____ Height _____ Pulse _____

Blood Pressure_____/_____ LMP_____ Temp _____

Birth Control:_____ Gravity:_____ Parity:_____

Pregnancies:_____

Menarche: _____ Interval: _____ Duration:_____

Most Recent Pap:_____ result:_____

Most recent Mammo:_____ resullt:_____

Most recent BMD:_____ result:_____

Most recent Colonoscopy:_____ result:_____

Medical Problems:_____

Surgeries:_____

Family History: Any Breast, Colon or Ovarian Cancer? If yes who_____

Mom: _____ Dad:_____

Brother/Sister:_____

Grandparents:_____

Married/single/widow/divorced/in relationship

Work: Full time/ Part Time Occupation:_____

Smoking? How much? _____ How long?_____ Alcohol Use?_____

Sexually Active?_____ STD's?_____