AVENUES FOR HEALTH
901 San Ramon Valley Blvd
Suite 130
Danville, CA 94526
(925) 820-6456

Name: _____
Date:_____/___/____

Referred by: _____

New Patients INTENTION FOR THIS APPOINTMENT:

_____
_____
_____
_____

AGE: _____ GENERAL HEALTH: Excellent Good Fair Poor
Preferred Pronoun _____

ALLERGIES
Drug Allergies: _____
Other Allergies: _____

MEDICATIONS (includes birth control pills, hormones & all prescription medication)

	Name	Dose	Schedule (daily, AM & PM)
1.			
2.			
3.			
4.			
5.			
6.			

VITAMINS & SUPPLEMENTS (include brand & dose)
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

_____
_____

CURRENT MEDICAL CONDITIONS OR PROBLEMS:

_____
_____
_____

Last Menstrual Period _____
When was your last Annual exam?_____ Doctor_____
When was your last pelvic exam? _____ Doctor _____
When did you last have blood tests? _____Which lab? _____

Prior Testing; mark date *(month/year)* of last test and circle if the test was abnormal
PAP smear _____ Abnormal Pap _____ Positive HPV _____
Mammogram:_____where?_____Breast Ultrasound:_____Breast MRI: _____
Colonoscopy: _____Doctor_____Bone Density _____ where? _____
Pelvic Ultrasound_____Hereditary Cancer Screening _____
STI testing Chlamydia_____ _ Gonorrhea_____ HIV_____ Syphilis_____Hepatitis C_____
EKG _____ Treadmill Stress Test/Echo _____ Other _____

Operations/Hospitalizations

Dates Hospital Operation/Diagnosis

_____

_____

_____

_____

PAST MEDICAL CONDITIONS

__Diabetes High Blood Pressure High Cholesterol Blood Clots/Embolus
__Arthritis Asthma Lung disease Fibromyalgia Sleep Apnea
__Heart Attack Stroke Migraines Seizures Heart murmur Eating Disorder
__Anxiety Depression Obsessive-Compulsive Panic Disorder Fractures
__Endometriosis Fibroids Ovarian Cysts Abnormal PAP Pelvic infection
__Constipation Diarrhea Irritable Bowel Rectal or GI Bleeding
__Cancer (type, date of diagnosis, treatment)

_____

_____

HEALTH HABITS

Exercise: __Yes __ No __ Occasionally
Aerobic: Type(s) _____ # days per wk _____ # minutes _____
Strength Training: Type _____ # days per wk _____ # minutes _____
Is your diet? Very Healthy Healthy Variable Poor
Dietary preferences/restrictions: _____
Do you smoke? No Quit/When_____Yes How much per day? _____
Alcohol: __Daily __4 or more drinks / week __Less than 4 drinks /week __Rare __Never
Do you have any health concerns about how much alcohol you drink? Yes No Maybe
Do you drink Coffee Green/Black Tea Soda Diet Soda How much/day? _____
Do you use marijuana? _____ *Any other recreational drugs?*_____

SOCIAL HISTORY

Circle married partnered single dating separated divorced widowed poly
Occupation:_____

STRESSES: (self, work, family, grief, etc)

_____

_____

_____

_ _____

Are you experiencing any verbal or physical abuse at home or at work? Yes No
Do you feel safe in your home? Yes __No __
Have you ever been verbally or physically abused in the past? __Yes __No

GYNECOLOGIC HISTORY

Date of last period_____ Periods come every_____days Periods last for _____ days

Have you stopped having periods? __Yes __No __Changing
Any problems with your periods? __Yes __No Explain:_____
_____

Any bleeding between your periods? __Yes __No Any bleeding after intercourse? __Yes __No
PMS? __Yes __No Symptoms that bother you most _____
Do the PMS symptoms interfere with your quality of life or relationships? __Yes __No

Are you on hormone therapy? __Ye__ No If yes, when did you start hormone therapy? _____
Are you interested in getting information about treatment for menopausal symptoms? __Yes __No

Current Birth Control Method: Pill Patch Vaginal Ring IUD /type _____
Nexplanon Depo Vasectomy Condoms Tubal Diaphragm None
Prior methods of contraception: _____
Any problems with prior methods? _____

Have you had any new sexual partner(s) in past year? __Yes __No
Are your sexual partners __men __ women __ both
Have you had any unprotected sex? __ Yes __ No
Do you want an STD/STI screen? __Yes __No __HIV testing
Any history of Herpes Genital warts Chlamydia Syphilis other STD _____

Have you ever been sexually abused or raped? __Yes __ No
If yes, is there anything you would like me to know? _____

Are you having? *circle*
Vaginal Discharge Vaginal Dryness Vaginal odor Pain with sex Pelvic Pain
Hot Flashes Night Sweats Insomnia Decreased Libido Irritability Hair loss
Accidental loss of urine/stool Urinary frequency or urgency Abdominal Bloating
Difficulty concentrating Decreased short term memory new joint pain

PREGNANCIES
Pregnancies _____ #live births _____ # Vaginal births_____ # C-sections _____
Birth weight of largest baby_____lbs___oz List ages/gender of children _____

FAMILY HISTORY

Member	Living? / Age	*Significant diseases		Cause & age at death
Mother				
Father				
Sister(s)				
Brother(s)				
Maternal GM				
Paternal GM				

Maternal GF				
Paternal GF				

*Breast, Colon, Uterine, Ovarian, Pancreatic or Prostate Cancer, Melanoma, Heart Disease, High Blood Pressure, Stroke, Diabetes, Osteoporosis, Alcoholism, Drug addiction, Depression, Psychiatric Conditions, Hereditary illness

Any other family member with significant illnesses?

_____

_____

_____

REVIEW OF SYSTEMS circle any symptoms that is currently bothering you;

__Weight Gain __Weight Loss __Appetite Change __Fatigue __Indigestion __Increased Gas/Flatulence
__Bloating __Nausea or Vomiting __Diarrhea __Constipation __Change in bowel habits __Hemorrhoids
__Chest Pain __Palpitations __Dizziness __Shortness of Breath __Abdominal Pain __Headaches
__Breast lump __Breast Pain __Nipple Discharge __Persistent Cough __Depression __ Anxiety __ Other