

Please complete before arriving for your appointment. This is part of your medical record and is kept absolutely confidential.



tending to the unique nature of women

1301 Taylor St
Suite 6-J
Columbia, SC 29201

ESTABLISHED PATIENT HISTORY FORM

Date:

(If you have not been seen here in the past three years, please complete the new patient history form)

Name:	SSN:	Age:	Date of Birth:
Primary Care Physician:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widow <input type="checkbox"/> Divorce	

Reason for visit:

Current Medications:					
(Also include all vitamins, herbs, and any frequently used over the counter medications)					
Drug Name:	Dosage:	Prescribed by:	Drug Name:	Dosage	Prescribed by:

_____ I have a Universal Medication Form (attached)

Allergies: (Drug name and reaction)			
Drug Name	Reaction	Drug Name	Reaction

Do you have a latex allergy? Yes No

SINCE YOUR LAST VISIT:	
Have you had Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please List:
Any new illnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please List:
Any changes in family history? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please List:

Current Birth Control:	
Date of last pap:	
Date of last mammogram:	
Date of last colon screening:	
Are you a smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No	How much?

Review of Systems								
Please check if you are currently experiencing the symptoms below								
Symptom	Y	N	Symptom	Y	N	Symptom	Y	N
Weight loss/gain			Irregular heartbeat			Fatigue		
Constipation/diarrhea			Visual problems			Urinary leakage		
Chest pain			Frequent urination			Difficulty breathing		
Painful urination			Joint/muscle pain			Frequent headaches		
Breast Pain			Depression/anxiety			Breast Discharge		
Hot flashes			Abnormal thirst			Hair loss		