Address: 2020 Rock Springs Road Smyrna, TN 37167 Phone: 615-223-0200 Fax: 615-223-8704A picture containing star, night, night sky

Description automatically generated

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_

Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit:

**Drug allergies + reaction:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Food allergies + reaction:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gynecologic history:**

* Age of first menstrual cycle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Are you sexually active? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What are you using to prevent pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* When was your last pap smear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⎕ Never had
  + Have you ever had an abnormal pap smear? \_\_\_\_\_\_\_\_\_\_\_
* When was your last mammogram? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⎕ Never had
* When was your last colonoscopy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⎕ Never had
* When was the 1st day of your last menstrual cycle? \_\_\_\_\_\_\_\_\_\_\_\_
* How often do you have your cycle? Circle one below.

Every 28 days Every 32 Days More frequently than 28 days Further apart that 32 Days

|  |  |
| --- | --- |
| Cycle length | Description of flow |
| * + 0-3 days | * + Light (1-3 tampons/pads a day) |
| * + 4-6 days | * + Moderate(4-7 tampons/pads a day) |
| * + 7+ days | * + Heavy (8+ pads/tampons a day |

* Menstrual cycle description: (circle one in each column)

**Medical History**: please select ALL that apply

* Abnormal pap smear
* Anemia
* Blood clots
* Bleeding disorder
* Breast disease
* Cancer
* Diabetes type 1 or type 2
* Ectopic pregnancy
* Gestational diabetes
* HIV
* Heart disease
* Herpes Simplex Virus
* OTHER (please list below):
* High blood pressure
* Liver or kidney disease
* Migraines with aura (visual or auditory changes)
* Miscarriage
* Pre-eclampsia (Toxemia)
* Preterm labor
* Hepatitis
* Seizures
* Stroke
* Syphilis
* Thyroid disease

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you completed the Gardasil Vaccine (Human Papillomavirus 9 Valent)?

* Yes, age/year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No

**Surgeries and hospitalizations**: (please list any additional on last page)

|  |  |  |
| --- | --- | --- |
| Name | Year | Reason |
|  |  |  |

**Medications**: (Include supplements/vitamins. Please list any additional on last page)

|  |  |  |
| --- | --- | --- |
| Name | Dose | Reason for use |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Obstetrical History:**  (please list any additional on last page)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Delivery date** (format as XX/XX/XXXX) | **Outcome**: (miscarriage, abortion,  vaginal birth, c-section) | **Gestational age** (total number of weeks at the end of the pregnancy) | Baby’s **sex** | Baby’s **weight** | Any **complications** with the pregnancy (include diabetes, blood pressure, preterm labor) |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Family History**:

Any **family** history of the following: Relationship Age of diagnosis

* + Breast Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + Ovarian cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + Colon cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + Uterine cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + Pancreatic cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all other family medical history:

* Paternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Maternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

|  |  |  |
| --- | --- | --- |
|  | Amount/type | Frequency (#/week or #/day) |
| Exercise |  |  |
| Alcohol use |  |  |
| Tobacco use |  |  |
| Drug use |  |  |

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender identity or pronouns: \_\_\_\_\_\_\_\_\_\_\_

Relationship status:

* Single
* Partnered
* Married
* Divorced/widowed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: Date of Service: