

Pt's Name _____ Date of Birth _____ Age _____ Today's Date _____
 Email: _____ Pharmacy # _____

With whom may we discuss test results or therapies? _____

At what phone number can we leave a secured voice mail? _____

1. GYNECOLOGICAL HISTORY: Any gynecological problems since your last examination? Yes; No (If yes, please explain)

- First day of last period _____ - Date of last Mammogram _____
- Duration of flow _____ - Date of last Pap Smear _____
- Time between periods _____ - Are you sexually active? _____
- Date of last Bone Density Scan _____ - Do you use contraception? Yes; No (If yes, type?) _____
- Colonoscopy? Yes; No If yes, when? _____ - Are you done having children? Yes; No

2. MEDICAL HISTORY: Any medical problems since your last examination? Yes; No (If yes, please explain)

- Do you take calcium? Yes; No
- List current Medications with the dosages
(include vitamin and herbal supplements) _____
- List any Allergies to Medication _____
- Any Surgeries/Hospitalizations since your last examination? (If yes, please explain): _____

3. FAMILY HISTORY: Any changes to your family history since your last examination? Yes; No (If yes, please explain)
(For example, breast cancer, ovarian cancer, uterine cancer and/or colon cancer, > 10 polyps on colonoscopy?)

- Ashkenazi / Jewish Ancestry? Yes; No

4. SOCIAL HISTORY: Any changes to your social history since your last examination? Yes; No

- Do you exercise regularly? Yes; No Current Occupation: _____
- Marital status? Single Married Separated Divorced Widow Same Sex Partner
- Do you smoke cigarettes? Yes; No If yes, at what age did you start? _____ Packs per day? _____
- Do you drink alcohol? Yes; No If yes, amount? _____ If yes, how often? _____
- Do you use drugs socially? Yes; No If yes, amount? _____ If yes, how often? _____
- Are you a victim of domestic violence or abuse in your present relationship? Yes; No Past Relationship? Yes; No
- Do you have a living will? Yes; No
- Do you have a medical power of attorney? Yes; No If yes, please supply a copy.

5. REVIEW OF SYSTEMS

Abdomen:

Diarrhea? Yes No Constipation? Yes No Other: _____

Genitourinary:

Frequent urination? Yes No Urinary Incontinence? Yes No Other: _____

Skin/breast:

Lumps in breast? Yes No Nipple discharge? Yes No Other: _____

Any other problems?

Completed by: _____ Date: _____

Reviewed by: _____ Date: _____

(Signature of Provider)

Acknowledgment of Receipt of Privacy Notice

Desert Sage

By signing below, I acknowledge that I have been provided with a copy of Desert Sage Notice of Privacy Practices and have therefore been advised of how health information about myself may be used and disclosed by Desert Sage and how I may obtain access and control this information.

* _____
(Signature of Patient or Guardian)

* _____
(Print Patient name or Guardian)

* _____
(Date)

* _____
(Description of Guardian)

Please list who you want to have access to your pertinent medical information, (i.e.: family member, spouse)

1. _____

2. _____

3. _____

May we leave a message on an answering machine? YES ___ NO ___

Preferred method of contact:

Home# _____

Cell# _____

Work# _____