



Medicine in
BALANCE

Name _____ Marital Status _____ Age _____ DOB _____

Address _____
(street) (city) (state)
zip)

Telephone (home) _____ (Work) _____ (ext _____)
(cell) _____

Fax number _____ Email address _____

Social Security Number: _____

Spouse / Partner Name _____

Primary Physician name and address: _____

MEDICAL HISTORY UPDATE (Must be fully completed for each visit.):

If you are here today for a GYN visit:

First day of last menstrual period _____

How long between periods? _____ How many days of bleeding? _____

Total number of pregnancies _____ # living children _____ Full term deliveries _____

Premature _____ stillborn _____ ectopic _____ Miscarriages _____ abortions _____

Please list all illnesses that you have had over the years: _____

NEW medical Issues since last visit: _____

Do you have any bladder concerns...even mild incontinence? [] yes [] no

Surgeries since last visit: _____

Allergies: Drug _____ Environmental _____

Medications I take: _____

Supplements, Vitamins, herbs and over-the-counter medicines I take: _____

Current birth-control method _____

Cigarettes _____ pks/day Alcohol _____ number of drinks or
oz/day

Do you feel that you are currently in an abusive relationship?[] yes [] no

Reason for today's visit: _____

Signature _____ Date _____

Instructions:
Answer all items to the best of your knowledge. For additional space, please continue on the back of the page.