

Date _____

CHAPERONE:
Accepted _____
Declined _____

Return History Form

Name: _____ Place sticker here Age: _____

Reason for Visit: _____

Other Care Providers: _____

New Medications or dose changes:

Hormones (prescription or non-prescription):

Other medications (include vitamins and non-prescriptions with doses):

New Allergies:

Dates of last:		Normal?
Mammogram:	_____	_____
Pap smear:	_____	_____
Bone mineral density:	_____	_____
Colonoscopy/sigmoidoscopy:	_____	_____
First day last menstrual period (if applicable):	_____	_____
Problems with menses or abnormal bleeding/discharge?	_____	_____

Since last visit:

Any changes in family history?

Any significant new medical problems or surgery?

Problems with heart, lungs, eyes, kidneys, liver, stomach, intestines, thyroid, breast, headaches change in weight, appetite, urine function, bowel function (describe):

Sexually active? _____ New partners since last visit?: _____

Birth control method (used by you or your partner): _____

Health Habits:	No	Yes
Cigarettes:	_____	_____
Alcohol	_____	_____
Regular exercise	_____	_____

Thank you for completing this form, it allows us to spend more time addressing your concerns.

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For office use only:

Vitals: Weight: _____; Height: _____; BP: _____; P: _____