1. Medical History

Have you ever been diagnosed with any of the following conditions? (Please select all that apply and provide additional comments where prompted)

- ☐ Cancer (Type: _____)
- ☐ Cardiovascular (e.g., heart attack, hypertension) _____
- ☐ Dermatologic (Skin conditions) _____
- ☐ Endocrine (e.g., Diabetes, Thyroid disorders) _____
- ☐ ENT (Ear, Nose, Throat) _____
- ☐ Gastrointestinal _____
- ☐ Hematologic (Blood disorders) _____
- ☐ Infectious Diseases _____
- ☐ Musculoskeletal (Muscle/bone/joint issues) _____
- ☐ Neurological (e.g., seizures, stroke) _____
- ☐ Ophthalmologic (Eye conditions) _____
- ☐ Psychological (e.g., Depression, Anxiety) _____
- ☐ Pulmonary (Lung conditions) _____
- ☐ Rheumatologic (Autoimmune, arthritis) _____
- ☐ Urologic (Kidney, bladder issues) _____
- ☐ Womens Health (e.g., PCOS, Endometriosis) _____
- ☐ Other conditions: _____

2. Surgical History

Have you had any of the following surgeries? (Select all that apply)

- ☐ Cardio-thoracic (Heart or Chest)
- ☐ Colon and Rectal

☐ Endocrine (e.g., thyroidectomy)

☐ General Surgery (e.g., appendectomy, hernia)

☐ Neurosurgery

☐ Gynecologic/Obstetric (e.g., C-section, hysterectomy)

☐ Orthopedic (e.g., joint replacement)

☐ Eye Surgery

☐ ENT/Otolaryngologic

☐ Urologic

☐ Vascular

☐ Other (Please specify): _____

3. Screenings & Tests

Please provide the most recent dates (if known) for the following screenings and tests:

- Pap smear: ___ / ___ (MM/YYYY)

- Mammogram: ___ / ___ (MM/YYYY)

- Colonoscopy, Cologuard, or FIT test: ___ / ___ (MM/YYYY)

- Cardiac tests (e.g., Echocardiogram, EKG, Stress Test):

  - Test type(s): _____

  - Date(s): ___ / ___ (MM/YYYY)

- Diabetic eye exam: ___ / ___ (MM/YYYY)

4. Family Medical History

Have any of your family members been diagnosed with the following conditions? (Select all that apply and list relation)

- Cancer: _____

- Diabetes: _____

- Heart disease: _____

- High blood pressure: _____

- Stroke: _____

- Mental illness: _____

- Genetic conditions: _____

- Other (Please list condition and relation): _____

5. Gynecological & Reproductive History

- Are you sexually active? ☐ Yes ☐ No

- Do you use birth control? ☐ Yes ☐ No

  - If yes, what type? _____

- Have you ever been pregnant? ☐ Yes ☐ No

  - Number of pregnancies: _____

  - Carried to term: _____

- Planning to become pregnant in the next year? ☐ Yes ☐ No

6. Social History

Tobacco/Nicotine Use (Select all that apply)

☐ Never used ☐ Current user ☐ Former user ☐ E-cigarettes/Vaping ☐ Smokeless tobacco

Alcohol Use

☐ Never ☐ Occasionally ☐ Socially ☐ Regularly ☐ Heavily ☐ Former user

Recreational Drug Use

☐ Never ☐ Occasionally ☐ Regularly ☐ Marijuana ☐ Cocaine ☐ Ecstasy ☐ Former user Other: _____

7. Mental Health Assessment PHQ-2

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things

☐ ☐ ☐ ☐

(Select: Not at all, Several days, More than half the days, Nearly every day)

2. Feeling down, depressed, or hopeless

☐ ☐ ☐ ☐

(Select: Not at all,Several days, More than half the days, Nearly every day)

8. Certified Medical Chaperone

Some states require a certified medical chaperone to be present during certain sensitive exams (e.g., breast, genital, rectal).

- Would you like a certified medical chaperone present? ☐ Yes ☐ No

- If no, please indicate reason: _____

Note: If you decline a certified chaperone, your provider may choose not to perform the exam. Please discuss this with your provider.