

Imana Medicine / Annie Rafter, RNC, CNP

Legal Name: \_\_\_\_\_
Preferred Name: \_\_\_\_\_
Address: \_\_\_\_\_
City: \_\_\_\_\_
Home Phone: \_\_\_\_\_ Work \_\_\_\_\_
Mobile Phone:( --- ) \_\_\_\_\_
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Date: \_\_\_\_\_
E-Mail: \_\_\_\_\_
SS #: \_\_\_\_\_
State/Zip: \_\_\_\_\_
Insurance Co: \_\_\_\_\_
Occupation: \_\_\_\_\_
Referred by: \_\_\_\_\_

Social History

Are you in a committed relationship? [ ] Yes [ ] No
Are you Married [ ] Yes [ ] No
Cigarettes per day? \_\_\_\_\_ Now \_\_\_\_\_ Past
Do you use recreational drugs? [ ] Yes [ ] No
What routine exercise do you do? \_\_\_\_\_
Are you under a lot of stress? \_\_\_\_\_
Describe your diet in general: \_\_\_\_\_

Name of Partner: \_\_\_\_\_
Partner Phone#: \_\_\_\_\_
Alcohol (amount per wk.) \_\_\_\_\_
Coffee(cups per wk.) \_\_\_\_\_ Tea \_\_\_\_\_
What is the source? \_\_\_\_\_

Medical History

- Alcoholism, Asthma, Blood Clots, Blood Trans., Cancer, Chicken Pox, Diabetes, Eczema, Gastric Problems, Glaucoma, Headaches, Heart Disease, Hepatitis, High Blood Pressure, Kidney Disease, Lung Disease, Measles, Mental Health Issues, Migraines, Pneumonia, Scarlet Fever, Seizures, Stroke, TB, Thyroid Problems, Ulcers, Urinary Infections, Vein Problems

Any Serious or chronic problems?

Any Drug Reactions/ Allergies

List Medications, Vitamins, Herbs you are now taking:

List Hospitalizations, operations and include reason(s) and dates(s):

Have you ever been exposed to incest, rape, or other sexual abuse [ ] Yes [ ] No
In the last year, have you been threatened or experienced any kind of violence? [ ] Yes [ ] No

Gynecological / Obstetrical History

At what age did your period begin? \_\_\_\_\_ At what age did it end? \_\_\_\_\_
Number of day between periods? \_\_\_\_\_ Number of day flow? \_\_\_\_\_
Any Current Unusual Bleeding? [ ] Yes [ ] No Do you experience PMS [ ] Yes [ ] No
Are you a DES Daughter? [ ] Yes [ ] No
Do you have a history of sexually transmitted disease?(Chlamydia, Gonorrhea, Herpes, Trichomonas, Syphilis, HPV) Yeast Infections? Please list: \_\_\_\_\_
Date of Last Pap? \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_ Practitioners Name: \_\_\_\_\_
Have you had an abnormal pap?[ ] Yes [ ] No If yes how was it treated? \_\_\_\_\_: \_\_\_\_\_
Have you experienced unusual breast changes or discharges? [ ] Yes [ ] No Have you had a Colonoscopy? [ ] Y [ ] N Date \_\_\_\_\_
# of Pregnancies \_\_\_\_\_ # of Living Children \_\_\_\_\_ # of Miscarriages \_\_\_\_\_ # of Abortions \_\_\_\_\_ Age of First Pregnancy \_\_\_\_\_
Are you sexually active now? [ ] Yes [ ] No # of partners \_\_\_\_\_ What is your current birth control method? \_\_\_\_\_

Family History

- Alcoholism, Alzheimer's, Arthritis, Asthma, Birth Defects, Bleeding Disorders, Cancer, Diabetes, Epilepsy, Gall Bladder, Genetic Disorders, Glaucoma, Gout, Heart Disease, High Blood Pressure, Other, Kidney Disease, Mental Illness, Migraines, Osteoporosis, Stroke, TB, Thyroid Disease

Do you have any other concerns that you have not mentioned on this form? (Y) (N) If yes please list on back

