LAWRENCE L. LIN, MD 2190 LYNN ROAD SUITE 240 THOUSAND OAKS, CA 91360 OFFICE (805)449-1778 FAX (805)496-9970

NAME: _____ DATE: _____ AGE: _____ DATE OF BIRTH: _____ SSN: _____

Primary Care Physician: _____ Referring (Physician): _____

Other physicians you see regularly: _____

Preferred Pharmacies (Name, cross streets or phone number): _____

What brings you in to see us today?

_____

_____

_____

*Do you have any **ALLERGIES?** (Please use the back of this sheet if you need more space.)* ☐ *NO*

Allergic to:	*What kind of reaction do you get:*

*What **MEDICATIONS** do you currently take? (Please use the back of this sheet if you need more space.)* ☐ *NONE*

Name of Medication	*Dosage*	*Times per day*	*Reason for taking*

PAST MEDICAL HISTORY: ☐ *NONE*

☐ Anemia	☐ Breast problems	☐ GI problems	☐ Lung disease	☐ Seizures/epilepsy
☐ Anesthesia complications	☐ Cancer	☐ Heart disease	☐ Lupus	☐ Stroke
☐ Anxiety disorder	☐ Depression	☐ High blood pressure	☐ Mitral valve prolapse	☐ Thyroid disease
☐ Asthma	☐ Diabetes	☐ High cholesterol	☐ Osteoporosis	☐ Other: _____
☐ Bleeding/clotting disorders	☐ Fibromyalgia	☐ Kidney/bladder problems	☐ Pulmonary embolism	☐ _____

PAST SURGICAL HISTORY: ☐ *NONE*

☐ Anterior/posterior repair	☐ Cholecystectomy	☐ Hernia repair	☐ Plastic surgery	☐ Tonsillectomy
☐ Appendectomy	☐ Eye surgery	☐ Hysterectomy	☐ Prolapse repair	☐ TRAM breast reconstruct.
☐ Back surgery	☐ GI surgery	☐ Joint replacement	☐ Reconstructive surgery	☐ Tubal ligation
☐ Breast surgery	☐ GYN surgery	☐ Laparoscopy	☐ Sling	☐ Vaginal mesh repair
☐ Caesarean section	☐ Heart surgery	☐ Orthopaedic surgery	☐ Stents	☐ Other: _____
☐ Cancer surgery	☐ Ears/Nose/Throat surgery	☐ Pacemaker	☐ Thyroid surgery	☐ _____

FAMILY HISTORY: ☐ *NONE*

Family member	Anesthesia problems	Autoimmune disease	Bleeding or clotting disorder	Cancer (specify type)	Diabetes	Heart disease	High cholesterol	Hypertension	Kidney disease
MOTHER									
FATHER									
SIBLINGS:									

Family member	Liver disease	Lung disease	Neurologic disorders	Osteoporosis	Psychologic disorders	Stroke	Thyroid disease	Other (specify)
MOTHER								
FATHER								
SIBLINGS:								

PREGNANCY HISTORY:

# Total	
# Full term	
# Pre term	
# Miscarriage (Ab.S.)	
# Abortion (Ab.I.)	
# Ectopic	
# Multiple births	
# Living	

GYN HISTORY:

Duration of flow (# of days)	
Frequency of cycle	every ____ days
Monthly menstrual cycle	☐YES ☐ NO
Current birth control method	
Age (yrs.) at menopause (if applicable)	
Date of Last Menstrual Period	
Date (year) of last Pap smear	
Date (year) of last Mammogram	

SOCIAL HISTORY: *(Please circle or check where applicable.)*

Occupation:
Marital status: Married / Single / Divorced / Separated / Widowed / Domestic Partner
Smoking: None / 1 pk. per wk. / 2 ppw / ¼ pk. per day / ½ ppd / 1 ppd / 2 ppd / 3+ ppd
Alcohol: None / Occasional / Moderate / Heavy
Other drugs: ☐YES ☐ NO
Caffeine intake: None / Occasional / Moderate / Heavy
Domestic violence: ☐YES ☐ NO
Do you live: ☐ alone ☐ with others:

PLEASE CONTINUE ON TO NEXT PAGE →

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NAME: _____ DATE: _____ AGE: _____ DATE OF BIRTH: _____ SSN: _____

REVIEW OF SYSTEMS—Have you experienced any of the following conditions in the past month? Please circle ALL that apply.

01. CONSTITUTIONAL	NONE	weight loss ___#, weight gain ___#, fever/chills, fatigue, loss of appetite, headache
02. EYES	NONE	glaucoma, macular degeneration, vision changes, glasses/contacts, blurred vision, double vision, cataracts
03. ENT/MOUTH	NONE	hearing loss, sinusitis, nose bleeds, sore throat/difficulty swallowing, mouth ulcer/canker sores, bleeding gums
04. CARDIOVASCULAR	NONE	chest pain. palpitations, shortness of breath when lying flat, edema
05. RESPIRATORY	NONE	shortness of breath, chronic cough, sputum/productive cough, spitting up blood, wheezing
06. GASTROINTESTINAL	NONE	heartburn, nausea/vomiting, diarrhea, constipation, flatulence, bloody stools, jaundice
07. GENITOURINARY	NONE	blood in the urine, flank pain/kidney stones, incontinence with coughing/sneezing/laughing, incomplete emptying, urinary urgency, urinary frequency, urinate _____ times in 24 hours, nocturia ____ times per night, painful urination abnormal vaginal bleeding, rash, lesion, dry vaginal mucosa, vaginal discharge, vaginal odor, vaginal itching, painful sex, decreased libido, sexual dysfunction, prior history of sexually transmitted diseases
08. MUSCULOSKELETAL	NONE	muscle aches, muscle weakness, joint pain, joint stiffness, joint swelling, difficulty walking, cold extremities, gout, fracture, back pain
09. ENDOCRINE		
Menstrual	NONE	irritability, tension/anxiety, depressed mood, breast pain or tenderness, bloating, feeling out of control or overwhelmed
Menopausal	NONE	hot flashes, night sweats, impaired memory, impaired concentration
10. SKIN	NONE	abnormal moles, rash
11. NEUROLOGICAL	NONE	headache, dizziness, loss of consciousness, weakness, numbness, seizures
12. PSYCHOLOGIC	NONE	depression, alcoholism, sleep disturbances

ADDITIONAL SPACE if necessary: