Form Completed By: Date:

☐ 7965 Cardinal Court
Suite 240
San Diego, CA 92123

☐ 8860 Center Drive
Suite 360
La Mesa, CA 91942

☐ 6125 Paseo Del Norte
Suite 200
Carlsbad, CA 92011

Date: Preferred Language:
Patient Name: Date of Birth: / / Age:
Preferred pronouns (please circle): She/her He/Him They/Their
Name of PCP: How did you find WCOB?:
Reason for today's visit: Annual Exam: Y / N Other:

Current Medications/Supplements/Herbs (Rx or over the counter):

Name/Dose		

Allergies:

Trigger/ Reaction	

Medical Problems (Past and Current):

Dx (please mark all that apply)
Diabetes Type I or II
☐ High Blood Pressure
☐ Asthma/COPD
☐ Cancer (please describe):
☐ Sleep Apnea
☐ Depression or Anxiety Other Mental Health Dx?:
List any additional:

Previous Surgeries (including cosmetic):

Surgery/ Year preformed

Family History: mark all that apply or here if adopted/unknown ☐

Disease/Condition	Family member	Age at Dx
Cancer: ☐ Breast ☐ Uterine ☐ Ovarian ☐ Colon		
Other cancer:		
☐ Diabetes		
☐ High Blood Pressure		
☐ Osteoporosis		
☐ CVD/heart attack		
☐ Bleeding or clotting disorders		
List all others:		

Obstetric History (Pregnancies in order including miscarriages, ectopics, and abortions):

Date	# of Weeks (preterm?)	Birth Weight	Delivery Type	Sex (M/F)	Epidural (Y/N)	Complications

Method of birth control (please circle): Pills IUD Implant Ring Condoms Tubal Ligation Vasectomy
☐ Trying for pregnancy

Gynecologic History:

Monthly Cycle: Y / N	Age at menopause:
First day of last menses:	History of hormone replacement? Y / N
How many days do you bleed?	If yes, how long?
Do you bleed between menses: Y / N	
Are they heavy or painful? Y / N	
Date of last Pap Smear:	Results of last Pap Smear:
Have you ever had an abnormal Pap Smear? Y / N	If yes, when?
History of sexually transmitted infections? (circle if apply) HPV Herpes Chlamydia HIV Hepatitis C Syphilis Gonorrhea Trichomonas Others please list:	

Social/Substance/Sexuality:

Status: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Occupation: Hobbies:
Religion/Philosophy/Cultural affiliations:
Exercise type (days/wk):
of fruits/vegetables daily:
Alcohol use: Y / N monthly or less 2-3x/month 2-3x/wk >4x/wk
Tobacco use (include vape): Y / N
Drug use (past or present): Y / N Type:
Sexually active: Y / N with: ☐ Men ☐ Women ☐ Both Concerns:
History of abuse (sexual, emotional or physical)?: Y / N