

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	
<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Asthma/COPD
<input type="checkbox"/>	Cancer (please describe):
<input type="checkbox"/>	Sleep Apnea
<input type="checkbox"/>	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: <input type="checkbox"/> Breast <input type="checkbox"/> Uterine <input type="checkbox"/> Ovarian <input type="checkbox"/> Colon		
Other cancer:		
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> High Blood Pressure		
<input type="checkbox"/> Osteoporosis		
<input type="checkbox"/> CVD/heart attack		
<input type="checkbox"/> 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	
History of sexually transmitted infections? (circle if apply) HPV Herpes Chlamydia HIV Hepatitis C Syphilis Gonorrhea Trichomonas Others please list:	

Social/Substance/Sexuality:

Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> 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: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both      Concerns: _____
History of abuse (sexual, emotional or physical)?: Y / N

Form Completed By: \_\_\_\_\_

Date: \_\_\_\_\_