8391 Commerce Road, Suite 101
Commerce Twp., MI 48382
248-360-9090 • Fax 248-360-9093

Name: ______________________________ Age: __________ Date of Birth: ______________

Pronouns (optional): ________________

Last Menstrual Period: ________________

Method of contraception:
Pill Ring Condom IUD Depo-Provera Tubal Ligation Vasectomy Natural Abstinence Other

Do you: Use tobacco? Y / N Drink Alcohol? Y / N Use Recreational Drugs? Y / N Vape? Y / N

Please list your current medications (including vitamins, supplements, and over-the-counter meds):

____

____

Allergies to any medications?

____

Do you have any changes in your health, problems or concerns to be discussed today?

____

Have you had a new sexual partner since last exam? Y / N

We screen patients under 25 years old once a year for Chlamydia/Gonorrhea per CDC/ACOG guidelines to protect our patient's reproductive health. OK / Opt-Out

Would you like to be tested for HIV? Y / N

Current Relationship Status: ______________________
Please circle: Heterosexual Homosexual Bisexual Declined to Answer Other

Has anyone hurt you, or threated to hurt you? Have you been forced to have sex? Y / N

During the past month, have you been bothered by feeling down, depressed, or hopeless? Y / N
During the past month, have you been bothered by little interest or pleasure in doing things? Y / N

Would you like a nurse in the room during your examination? Y / N
Would you like a complementary consultation on skin care and/or laser hair removal? Y / N
Would you like the information regarding Advanced Healthcare Directives? Y / N

Patient Signature: ____ Date: ____________________

FOR OFFICE USE ONLY

BP: _________ /_________ **HT:** ____________ **WT:** _________ **PREV WT:** __________ **BMI:**____________

PAP: _____________ **MAMMO:** _______________ **BDT:** _________________ **COLON:** _______________

PCP: ________________________ **PHARMACY:** ____