WOMEN'S OB·GYN PC

NAME: CHT#:

APPOINTMENT DATE: AGE: BIRTHDATE:

PRIMARY CARE DOCTOR:

**WHY ARE YOU HERE TODAY (CC):**

**DR / PROVIDER COMMENTS:** LOCATION-QUALITY-SEVERITY-DURATION-TIMING-CONTEXT-MODIFYING FACTORS-ASSOCIATED SIGNS AND SYMPTOMS

**PATIENT TO COMPLETE BELOW:**

Number of pregnancies: _____ Number of children: _____ # of miscarriages/losses: _____

Last period: Date: _____ Cycle length: _____ Flow days: _____

Menstrual Flow Normal Y ☐ N ☐ Medium ☐ Heavy ☐ Clots Y ☐ N ☐

Painful periods: Y ☐ N ☐ Size: _____

Any Meds used: Y ☐ N ☐

Birth Control Method: Tubal ☐ Vasectomy ☐ Other _____

Last Pap Smear: _____ Prior Abnormal Pap Smear: Y ☐ N ☐

Age at First Period: _____ Menopause Age : _____

Painful lovemaking: Y ☐ N ☐

Self Breast Exam: Y ☐ N ☐

Last Mammogram Normal: Y ☐ N ☐

**PAST MEDICAL HISTORY:** Illnesses: (Diabetes, Hypertension, Heart, Thyroid, Asthma, etc.)

PHARMACY:

| Medications/Supplements/Herbal | Dose/Frequency | Reason |
|---|---|---|
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| | | |
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| Allergies to Medications or **LATEX** | Type of reactions (rash, hives, etc.) |
|---|---|
| | |
| | |

| Surgeries:(T&A, D&C, C/Section,etc.) | Reason | Who/Where/When | Year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Are you up to date with your immunizations? _____ If No, F/U with PCP ☐ _____

Bleeding tendency: Y ☐ N ☐ Rheumatic Fever: Y ☐ N ☐

Blood transfusions: Y ☐ N ☐ Scarlet Fever: Y ☐ N ☐

Gardasil: (Series Obtained) Y ☐ N ☐

**Please complete reverse side**

PATIENT NAME: _____ CHART: _____

**FAMILY HISTORY** (Mother, Father, Sister, Brother, Grandparents, Children, Aunts, Uncles, Cousins)

| Condition | Relationship | Type/where | Age of Cancer Dx | Status (Age Deceased - Remission - On Going) |
|---|---|---|---|---|
| Cancer/Breast/Ovarian | | | | |
| Cancer/Colon/Endometrial | | | | |
| Other Cancer | | | | |
| Diabetes | | | | |
| Heart Disease | | | | |
| Blood clots | | | | |
| High cholesterol | | | | |
| Hypertension/High Blood Pressure | | | | |
| Osteoporosis | | | | |
| Tuberculosis | | | | |
| Other | | | | |

**PERSONAL/SOCIAL:**

Marital Status: S ☐ M ☐ D ☐ W ☐

Tobacco: Current Use: N ☐ Y ☐ Wish to Quit: N ☐ Y ☐

Prior Use: N ☐ Y ☐ # Years: Stopped:

Alcohol Use: N ☐ Y ☐ Number of drinks per wk.:

Have you ever used alcohol or drugs to excess? N ☐ Y ☐

Have you ever considered decreasing/stopping? N ☐ Y ☐

Street Drugs: Ever Used: N ☐ Y ☐ Current: N ☐ Y ☐

Caffeine use: 8oz servings per day:

Total number of sexual partners you have had: Male: Female:

Did your mother take DES while she was pregnant with you? (Prior to 1970) N ☐ Y ☐

How old were you when you began your sexual activity?

Physically/Sexually Abused: N ☐ Y ☐ Currently: N ☐ Y ☐

Exercise Regularly: N ☐ Y ☐ Type:

Employment:

**REVIEW OF SYSTEMS:**

Check yes to any problems and **CIRCLE YOUR PROBLEM**

**General:** (Fatigue, Wt. gain, Wt. loss, fevers) N ☐ Y ☐

**Eyes:** (Visual changes, Glaucoma) N ☐ Y ☐

**Ears/Nose/Throat:** (Hearing, Sinus, Oral lesions, and/or difficulty swallowing N ☐ Y ☐

**Respiratory:** (Cough, Sputum production, Asthma, prior pneumonia, bloody sputum) N ☐ Y ☐

**Cardiovascular:** (Chest pain, Shortness of breath, palpitations, prior heart attack, etc.) N ☐ Y ☐

**Gastrointestinal:** (Nausea, Vomiting, Diarrhea, constipation, abdominal pain, food intolerance, ulcer, blood/mucus or change in stool) N ☐ Y ☐

**Urinary:** (Urinary tract infection, Urgency/frequency, bloody urine, loss of urine with cough/sneeze) N ☐ Y ☐

**Musculoskeletal**: (Arthritis, Injuries, Limitations) N ☐ Y ☐

**Skin/Breast:**(Change in mole or lesion,UV exposure to sun/tanner, breast change/discharge,excess hair growth) N ☐ Y ☐

**Neurological:** (Weakness, Numbness, Tingling, Seizures, Headaches, Etc.) N ☐ Y ☐

**Psychiatric:** (Depressed, Moody, Suicidal thoughts) N ☐ Y ☐

**Endocrine:** (Heat or cold intolerance, or ↓ in appetite, or ↓ in thirst or urination N ☐ Y ☐

**Anemia:** ( Past anemia/blood disorders) N ☐ Y ☐

**Allergy/Immunization**(Food/insect allergies/HIV risk) N ☐ Y ☐

**Are there any other questions for your provider?** N ☐ Y ☐

**PATIENT SIGNATURE:** **PROVIDER SIGNATURE**