Name________________ Date________ D.O.B.________

Occupation________________ Marital Status S M D W Age________

What is the purpose of your visit?________________

____

Referred to our office by:________________

If you have a specific problem, please describe briefly:________________

____

How long have you had this problem?________________

Have you consulted anyone else? Y N Who?________________

Describe any previous testing &/or treatment:________________

____

____

Please list all medications you are currently taking. Please include over the counter medications and herbal supplements.________________

____

____

Do you take calcium? Y N

Please list all allergies to medications, latex, foods:________________

____

GYNECOLOGY REVIEW

Last Pap smear__________ Last Mammogram__________ Last Bone Density__________

Date last period began:__________ Age your period began:__________

How often does your period come?
- ☐ Less than 20 days apart
- ☐ 21 - 30 days apart
- ☐ 30 - 40 days apart
- ☐ greater than 40 days apart

How many days do you usually flow?
- ☐ Less than 2 days
- ☐ 2 - 7 days
- ☐ 7 - 10 days
- ☐ more than 10 days

I use ________ pads ________ tampons on my heaviest days

Do you stay in bed during your period?	Y	N	Uterine Fibroids	Y	N
Do you bleed or spot in between periods?	Y	N	Ovarian Cysts	Y	N
Do you bleed or spot after intercourse?	Y	N	Uterine Cancer	Y	N
Do you require additional overnight protection?	Y	N	Cervical Cancer	Y	N
Do you have significant pain with your period?	Y	N	Other Cancer ________		

If yes, what do you usually take?________________ Dosage?________

____

Have you reached Menopause?	Y	N	Age of onset:________		
Do you have hot flashes?	Y	N	Night sweats?	Y	N
Vaginal dryness / painful intercourse?	Y	N	Trouble sleeping	Y	N
Do you take hormone replacement therapy?	Y	N			

Medication taken:________________

Duration of treatment:________________

Reason for discontinuation?________________

Herbal or natural supplements:________________

What form of birth control do you usually use?

- ☐ Birth control pills / Name________ for how many yrs./mos.________
- ☐ IUD Type / date of insertion________
- ☐ Vasectomy
- ☐ Diaphragm
- ☐ Rhythm/Natural Family Planning
- ☐ Condoms / Foam / Suppositories
- ☐ Tubal Ligation
- ☐ Menopause
- ☐ Hysterectomy
- ☐ Not sexually active
- ☐ Other:________________

Do you have pain during or after intercourse? Y N
Do you have any concerns with sexual function/desire? Y N

Do you have concerns with PMS? Y N

Do you perform monthly breast self-exams? Y N
Any significant breast changes that you have noticed?____________________
Do you have: ☐ breast lumps ☐ nipple discharge ☐ breast tenderness
Fibrocystic breast changes____________________
Do you have a chronic vaginal discharge? Y N
Have you used medication for the discharge? Y N Meds. used:__________
Do you douche? Y N If so, how often?__________ What do you use?__________
Have you been treated in the past for a vaginal infection? Y N

- ☐ Yeast
- ☐ Chlamydia
- ☐ Herpes/HSV virus
- ☐ Trichomonas
- ☐ Gardnerella
- ☐ HIV/AIDS
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Pelvic Inflammatory Disease
- ☐ Bacterial/BV
- ☐ HPV/genital warts

Have you ever had an abnormal pap smear? Y N What year?__________
Describe any treatment/follow-up:____________________

Burning on urination Y N Blood in the urine? Y N
Urinary tract infection Y N How many infections?__________
Urinary frequency Y N Urinary urgency Y N
Do you get up in the middle of the night to urinate? Y N
Do you wet yourself when you cough/laugh/exercise? Y N
Have you seen a Urologist in the past? Y N
Do you wear pads for urinary leakage? Y N

SOCIAL HISTORY

Do you consume caffeine daily? Y N Chocolate ________ servings/day
Coffee / Tea __________ servings/day
Carbonated soft drinks __________ servings/day
Do you consume alcohol on a regular basis? Y N Drinks/week__________
Do you smoke? Y N How much?__________
Have you ever smoked cigarettes in the past? Y N When quit?__________
Have you used illicit or IV drugs in the past? Y N ☐ Marijuana ☐ Cocaine ☐ Methadone other__________
Do you exercise? Y N
Do you have any history of family violence? Y N
Do you use a seat belt? Y N
Do you use sun screen? Y N

FAMILY HISTORY

Relationship	Age	State of Current Health	Age at Death	Medical Conditions
Mother				
Father				
Brother				
Sister				
Spouse				

Name ______________________________ Date of Birth ______________

SURGERIES AND HOSPITALIZATIONS

List all except obstetrical: (Use a separate sheet of paper if more space is needed)

Surgery/Hospitalization	Date	Reason/Diagnosis

OBSTETRICAL HISTORY

Please list pregnancies, miscarriages and terminations from past to current.

Date	Vaginal	C-Section	Abortion	Miscarriage	Male/Female	Weight	Complications

IF HERE FOR PREGNANCY CARE, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Will you be age 35 or older when the baby is due? Y N
   Age when due: ______________
2. Have you or the baby's father, or anyone in either of your families ever had:
   A. Down syndrome or mongolism? Y N
   B. Spina bifida or meningomyelocele (open spine)? Y N
   C. Hemophilia? Y N
   D. Muscular dystrophy? Y N
   E. Cystic fibrosis? Y N
3. Have you or the baby's father had a child born dead or alive at birth with a birth defect not listed in Question 2 above? Y N
   If yes, please describe: ______________
4. Do you or the baby's father have any close relatives who are mentally retarded? Y N
   If yes, list cause, if known: ______________
5. Do you or the baby's father or close relatives in either of your families have any inherited genetic or chromosomal disease or disorder not listed above? Y N
   If yes, please describe: ______________
6. Have you had three or more spontaneous pregnancy losses? Y N
7. Do you or the baby's father have any close relatives descended from Jewish people who lived in Eastern Europe (Ashkenazic Jews)? Y N
8. If patient or the baby's father are Black:
   Have you or the baby's father or any close relatives been screened for sickle cell trait and found to be positive? Y N

Do you have now, or have you had within the past year:
(please circle the correct response beside each question)

Constitutional:
Weakness Y / N
Tire easily Y / N
Weight Change Y / N
Appetite Change Y / N
Other:____________________

Eyes:
Double Vision Y / N
Blurred Vision Y / N
Glasses/Contacts Y / N
Last Eye Exam____________
Other:____________________

Ears, Nose, Throat:
Ringing in ears Y / N
Ear pain Y / N
Hearing loss Y / N
Freq. nose bleeds Y / N
Sinus problems/Allergies Y / N
Loss of smell Y / N
Sore throat Y / N
Other:____________________

Cardiac/Vascular:
Palpitations Y / N
Heart flutter Y / N
Chest pain Y / N
Mitral Valve Prolapse Y / N
Other:____________________

Respiratory:
Chronic cough Y / N
Shortness Breath Y / N
Wheezing Y / N
Other:____________________

Endocrinology:
Increased thirst Y / N
Diabetes Y / N

Gastrointestinal:
Diff. Swallowing Y / N
Heartburn Y / N
Frequent Belching Y / N
Nausea/Vomiting Y / N
Chronic Diarrhea Y / N
Chr. Constipation Y / N
Rectal bleeding Y / N
Hemorrhoids Y / N
Irrit. Bowel Syndrome Y / N
Hepatitis A/B/C Y / N
Other:____________________

Musculoskeletal:
Backaches Y / N
Joint pain/stiff Y / N
Swollen joints Y / N
Muscle cramps Y / N
Swelling of hands/feet/ankles Y / N
Other:____________________

Integumentary: (skin)
Skin rash Y / N
Other:____________________

Neurological:
Headaches Y / N
Seizures Y / N
Poor Coordination Y / N
Dizziness/Fainting Y / N
Other:____________________

Psychological:
Depression Y / N
Memory loss Y / N
Other:____________________

Form completed by: ☐ Patient ☐ Medical Assistant ☐ Physician ☐ Other	
Signature of Patient:	
Date reviewed by Physician with Patient: / /	Physician Signature:

ANNUAL REVIEW OF HISTORY

Date Reviewed: / /	Physician Signature:
Date Reviewed: / /	Physician Signature:
Date Reviewed: / /	Physician Signature:
Date Reviewed: / /	Physician Signature:

******* For Physician Use ONLY *******

Date Reviewed	Physician's Initials	Date Reviewed	Physician's Initials	Date Reviewed	Physician's Initials	Date Reviewed	Physician's Initials