

Name _____ Age _____ Marital Status _____ Date _____

Reason for Visit

Allergies to Medications

If yes, please name medicine and describe type of reaction

Medications

Please give name and dosage

Pregnancy History

Total Pregnancies _____ Full Term _____ Pre-term _____ Miscarriage _____ Abortion _____ Ectopic _____

Date	Length of Pregnancy	Type of Delivery	Sex	Weight	Living	Complications
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Menstrual History

At what age did you start having menstrual periods? _____

Number of days between first day of one and first day of next period? _____

Length of period? _____ Regular or Irregular _____

Would you call your periods () light () medium () heavy () clots

When was the first day of your last menstrual period? _____ Do you have cramps? _____

Was it a normal period? _____ If not, when was the last normal one? _____

Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods/cramps? Y N

Contraception

What is your current form of birth control?

How long have you been using your current form of birth control? (please check one)

2 yrs or less 3-5 yrs 6-10 yrs over 10 yrs

When are you planning to have another child? (please check one)

within 1-2 yrs within 5-10 yrs my family is complete

Would you like information on a gentle, hormone-free permanent birth control procedure performed in the comfort of our office? Yes No

If menopausal, at what age did your periods stop? _____

Date of last pap smear? _____ Normal/Abnormal? _____ Have you had an abnormal pap smear? _____
If yes, please give dates, type (ASCUS, HPV, CIN I, etc.) and treatments (Colposcopy, Cryo, Cone Biopsy, LEEP)

Date of last mammogram? _____ Normal/Abnormal? _____ Have you had an abnormal mammogram? _____
If yes, please give dates and explain _____

Past Medical History

Please check if you currently have or have had a history of any of the following:

- | | | | | | |
|------------|-----------|--|------------|-----------|-----------------------------|
| <u>YES</u> | <u>NO</u> | | <u>YES</u> | <u>NO</u> | |
| () | () | Reflux/Heartburn | () | () | Kidney Stones |
| () | () | Spastic Colon/Irritable Bowel | () | () | Fibromyalgia |
| () | () | Hepatitis | () | () | Arthritis-Rheumatoid/Osteo |
| () | () | Ulcers | () | () | Diabetes |
| () | () | Hypertension | () | () | Thyroid Problems |
| () | () | Heart Disease | () | () | Osteoporosis |
| () | () | Angina | () | () | Nervous Disorder/Depression |
| () | () | Heart Murmur | () | () | Rheumatic Fever |
| () | () | Hypercholesterolemia | () | () | Migraines |
| () | () | Blood Clotting Problems/DVT | () | () | Dementia |
| () | () | Asthma | () | () | Stroke/TIA |
| () | () | Sleep apnea | () | () | Epilepsy |
| () | () | Tuberculosis | () | () | Anemia |
| () | () | Pneumonia | () | () | Sickle Cell Disease/Trait |
| () | () | Emphysema | () | () | Allergies |
| | () | () Tuberculosis | () | () | Eczema |
| () | () | Kidney/Bladder Infections | () | () | Psoriasis |
| () | () | Hospitalizations - If yes, please explain: _____ | () | () | Cancer _____ |

Past Surgical History

Dates: _____ Procedure: _____

Immunizations (please list dates)

Tetanus: _____ HPV: _____ Flu: _____
Who is your Primary Care Physician? _____

Family History

- | | | | | | |
|------------|-----------|----------------|------------|-----------|-------------------|
| <u>YES</u> | <u>NO</u> | | <u>YES</u> | <u>NO</u> | |
| () | () | Breast Cancer | () | () | Diabetes |
| () | () | Ovarian Cancer | () | () | Thyroid Disorder |
| () | () | Uterine Cancer | () | () | Osteoporosis |
| () | () | Colon Cancer | () | () | Epilepsy/Seizures |
| () | () | Heart Disease | () | () | Stroke |

- () () Hypercholesterolemia
() () Hypertension
() () DVT/Pulmonary Embolus

- () () Depression/Bipolar/Schizophrenia
() () Birth Defects
() () Other

If yes, please explain

Social History

Employer/Occupation _____ Marital Status _____
Exercise Type/Frequency _____ Education Level _____
Smoking _____cigs/day Alcohol _____drinks/wk Caffeine _____servings daily Illicit Drugs _____
Have you ever had a sexually transmitted disease? _____
Type/dates _____

Review of Systems: (Circle current symptoms)

GENERAL - Fatigue Fever Weight gain Weight loss

CARDIOVASCULAR - Palpitations Chest pain

PULMONARY - Cough Shortness of breath

GASTROINTESTINAL - Bloating Constipation Diarrhea Hemorrhoids Bloody stools Nausea

URINARY - Pain with urination Blood in urine Frequency UTI's Incontinence

GENITAL - Irregular periods Painful intercourse History of sexual abuse Vaginal discharge Vaginal itching

MUSCULOSKELETAL - Back pain Joint pain

BREAST - Perform self breast exams-Regularly/Irregularly/Never Masses Tenderness Nipple discharge

SKIN - Rash Warts

NEUROLOGIC - Dizziness Headaches

BLOOD/LYMPHATIC - Easy bruising Bleeding easily History of blood transfusion Enlarged lymph nodes

ENDOCRINE - Hair loss Temperature intolerance Excessive hair growth

ALLERGIES - Seasonal allergies

PSYCHIATRIC - Anxiety Depression PMS Insomnia
