Patient Name: _____
Today's Date: _____
DOB: _____
Referred by:_____
What is your reason for coming today?:
_____
_____

OB/GYN History
Please check all that apply:
[ ] Menopausal
If yes, state year: _____
[ ] Hysterectomy
If yes, state year: _____
Ovaries removed? (Y/N)

For patient's still having periods:
Date of last menstrual period:_____
Average length: _____
Average flow:
(Heavy, Light, Moderate)
Do you pass clots? (Y/N)
Do you have cramps:
(Mild, Moderate, Severe)
Any recent changes in periods?
_____
_____
_____

Present method of birth control (Including tubal ligation or vasectomy):
_____
Date of last Pap smear: _____
Result: _____
Ever had an abnormal pap smear? (Y/N)
Date of last mammogram: _____
Result: _____
Date of last colorectal screening: _____
Result:_____
Date of last bone density exam: _____
Result:_____

# of pregnancies: _____
# of living children: _____
# of vaginal deliveries:_____
# of C-sections: _____
# of miscarriages: _____
# of ectopic pregnancies: _____
# of abortions: _____

Current Medications
Please list all current medications you are taking (if more continue on back):
_____
_____
_____
_____

Family History
Please specify which relative for each illness and the age of onset:

Diabetes_____
Heart Disease_____
Blood Clots in Lung/Leg/Stroke_____
High Blood Pressure_____
High Cholesterol_____
Osteoporosis_____
Alcohol/Drug issues_____
Breast Cancer_____
Colon Cancer_____
Ovarian Cancer_____
Cervical Cancer_____
Uterine Cancer_____
Other Cancer_____
Mental Illness_____
(specify) _____
Other_____

Social History
Please check all that apply:
[ ] I have smoked in the past.
For how long? : _____
Date stopped: _____
[ ] I smoke currently.
Packs per day: _____
For how long? : _____

[ ] I drink.
Drinks per week: _____
Type of alcohol: _____
[ ] I have a history of illicit drug use.

Past Medical History
Please check all that apply:

[ ] Asthma
[ ] Kidney Infections
[ ] Kidney Stones
[ ] Tuberculosis
[ ] Infertility
[ ] HIV/AIDS
[ ] Heart attack
[ ] Heart Disease
[ ] Diabetes
[ ] High Blood Pressure
[ ] Blood clots in lungs/legs/stroke
[ ] Eating Disorders
[ ] Breast Cancer
[ ] Colon Cancer
[ ] Ovarian Cancer
[ ] Cervical Cancer
[ ] Uterine Cancer
[ ] Other Cancer
Please specify: _____
[ ] Reflux
[ ] Hiatal Hernia
[ ] Gastric ulcers
[ ] Mental Illness
Please specify: _____
[ ] Anemia
[ ] Blood Transfusion
[ ] Seizures/Convulsions
[ ] Bowel Problems
Please Specify: _____
[ ] Arthritis
Please Specify: _____
[ ] Back Problems
Please Specify: _____
[ ] Hepatitis
[ ] Liver Disease
[ ] Thyroid Disease

[ ] Bleeding Disorders
[ ] Other: _____

Past Operations
(*Please include date*):

_____
_____
_____
_____
_____

Review of systems
Please check all that apply to you currently:

Constitutional:
[ ] Unexplained weight Loss
[ ] Fever
[ ] Extreme fatigue
[ ] Change in Height
Eyes:
[ ] Recent vision Changes
[ ] Glasses
[ ] Contacts
Ear, Nose and Throat:
[ ] Earaches
[ ] Ringing in ears
[ ] Hearing problems
[ ] Sinus problems
[ ] Sore throat
[ ] Mouth sores
[ ] Dental problems
Cardiovascular:
[ ] Chest pain/pressure
[ ] Difficulty breathing on exertion
[ ] Swelling of legs
[ ] Rapid/irregular heartbeat
Respiratory:
[ ] Shortness of breath
[ ] Chronic cough
Gastrointestinal:
[ ] Frequent diarrhea
[ ] Bloody stool
[ ] Frequent Nausea
[ ] Frequent Vomiting
[ ] Heartburn
[ ] Chronic constipation
[ ] Involuntary loss of gas/stool
Genitourinary:
[ ] Blood in urine
[ ] Pain with urination
[ ] Strong urgency to urinate
[ ] Frequent urination
[ ] Incomplete bladder emptying
[ ] Involuntary urine loss
[ ] Urine loss due to coughing/lifting
[ ] Premenstrual Syndrome (PMS)
[ ] Pain with intercourse
Musculoskeletal:
[ ] Joint pain
Skin:
[ ] Rash
[ ] Moles (growth/changes)
Breasts:
[ ] Tenderness
[ ] Nipple discharge
[ ] Lump/Mass in breast
Neurologic:
[ ] Dizziness
[ ] Numbness
[ ] Frequent headaches
Psychiatric:
[ ] Depression
[ ] Anxiety
Endocrine:
[ ] Hair Loss
[ ] Hot flashes
[ ] Night sweats
Hematologic/ Lymphatic:

[ ] Difficulty stopping bleeding
[ ] Enlarged lymph nodes (glands)

Please list any medication allergies that you have and the response the medication causes:

_____
_____
_____
_____
_____