Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GYN HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Current method of birth control? Or N/A |  | Date of last Pap smear |  | Date of last mammogram: |  |
| Date of last menstrual cycle |  | Are you currently sexually active? |  | If in menopause ,what age did it occur |  |
| Age of first period |  | If not, have you ever been |  | Have you been a victim of abuse | \_\_\_\_Verbal \_\_\_\_Sexual |
| How many days does your period last |  | Have you been treated for STD’s |  |  | \_\_\_\_Physical \_\_\_\_Rape |

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|  |  |  |
| --- | --- | --- |
| \_\_\_\_Heavy menstrual flow | \_\_\_\_Hysterectomy /no uterus | \_\_\_\_Dyspareunia |
| \_\_\_\_Painful Periods | \_\_\_\_Removal of 1 ovary \_\_\_\_Removal of both | \_\_\_\_D&C |
| \_\_\_\_Irregular periods | \_\_\_\_Removal of 1 tube \_\_\_\_Removal of both | \_\_\_\_LEEP Cone biopsy |
| \_\_\_\_Last period > 1 year ago | \_\_\_\_Endometriosis | \_\_\_\_Tubal Ligation |
| \_\_\_\_Endometrial ablation | \_\_\_\_Hot Flashes | \_\_\_\_Gyn Surgery |
| \_\_\_\_Pelvic Pain | \_\_\_\_Night sweats | \_\_\_\_Infertility Treatment |
| \_\_\_\_Recurrent vaginal infections | \_\_\_\_Vaginal itching | \_\_\_\_Leaking of urine |
| \_\_\_\_Abnormal pap smear \_\_\_\_Colpo \_\_\_\_Repap \_\_\_\_\_other | \_\_\_\_Vaginal discharge |  |
| \_\_\_\_HPV \_\_\_\_HPV Vaccine | \_\_\_\_Vaginal tears |  |
| \_\_\_\_Genital Herpes | \_\_\_\_Vaginal dryness |  |

**OB HISTORY (**Please provide the number below)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **\_\_\_\_Pregnancies** | | **\_\_\_\_Live Births** | | **\_\_\_\_Miscarriage** | | **\_\_\_\_Abortion** | | **\_\_\_\_Multiple Births** |
| Date | GA Weeks | Birth weight | Sex | Delivery Type | Preterm Delivery | | Complications with pregnancy or delivery | |
|  |  |  |  |  |  | |  | |
|  |  |  |  |  |  | |  | |
|  |  |  |  |  |  | |  | |
|  |  |  |  |  |  | |  | |

**PAST MEDICAL HISTORY** C:\Users\Lylia\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\DXQ4HODR\120px-Check_mark_23x20_02.svg[1].png**CHECK ALL THAT APPLY**

|  |  |  |
| --- | --- | --- |
| \_\_\_\_Arthritis | \_\_\_\_Diabetes | \_\_\_\_Respiratory/Lung Disease |
| \_\_\_\_Asthma | \_\_\_\_Heart Disease | \_\_\_\_Seizures / Epilepsy |
| \_\_\_\_Auto Immune Disorder | \_\_\_\_Hypertension | \_\_\_\_Gastrointestinal Disease |
| \_\_\_\_Blood disease/Anemia | \_\_\_\_Kidney Disease | \_\_\_\_Stroke |
| \_\_\_\_Cancer | \_\_\_\_Liver Disease/Hep B | \_\_\_\_Thyroid disease |
| \_\_\_\_Urinary Tract Infection | \_\_\_\_Psychiatric Disorder | \_\_\_\_Other |

**PAST SURGICAL HISTORY** C:\Users\Lylia\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\DXQ4HODR\120px-Check_mark_23x20_02.svg[1].png**CHECK ALL THAT APPLY**

|  |  |
| --- | --- |
| \_\_\_\_Appendectomy | \_\_\_\_Tonsillectomy |
| \_\_\_\_Breast | **\_\_\_\_**Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_ Cholecystectomy |  |
| \_\_\_\_ Laparoscopic |  |

**SOCIAL HISTORY** C:\Users\Lylia\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\DXQ4HODR\120px-Check_mark_23x20_02.svg[1].png**CHECK ALL THAT APPLY**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \_\_\_\_Married | \_\_\_\_Single | | \_\_\_\_Divorced | | \_\_\_\_Separate | | \_\_\_\_Widowed | |
| Caffeine per day  (include coffee, tea, soda) | | \_\_\_\_0 | | \_\_\_\_1-3 | | \_\_\_\_4-6 | | \_\_\_\_More than 6 |
| Cigarettes | | \_\_\_\_No | | \_\_\_\_Yes | | \_\_\_\_per day | | ­\_\_\_\_Years |
| Alcohol | | \_\_\_\_Never | | \_\_\_\_Rarely | | \_\_\_\_Weekly | | \_\_\_\_Daily |
| Recreational Drugs | | \_\_\_\_No | | \_\_\_\_Yes | | Type of drug\_\_\_\_\_\_\_\_\_\_\_ | |  |

**MEDICATIONS** (please include dose and instructions) (including over the counter and supplements)

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |

**ALLERGIES** (list any medications, foods or seasonal allergies & the reaction)

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

**FAMILY HISTORY** (please mark M for maternal or P for paternal)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \_\_\_\_Arthritis | \_\_\_\_Diabetes | | \_\_\_\_Gastrointestinal | | \_\_\_\_Heart disease | | \_\_\_\_High Blood Pressure | | \_\_\_\_Joints | |
| \_\_\_\_Kidney Disease | \_\_\_\_Lung Disease | | \_\_\_\_Osteoporosis | | \_\_\_\_Psychiatric Disease | | \_\_\_\_Stroke | | \_\_\_\_Genetic Disease | |
| \_\_\_\_Breast Cancer | \_\_\_\_Cervix Cancer | | \_\_\_\_ Colon Cancer | | \_\_\_\_Lung Cancer | | \_\_\_\_Ovarian Cancer | | \_\_\_\_ Prostate Cancer | |
| \_\_\_\_Other | | | | | | | | | | |
| **REVIEW OF SYSTEMS** C:\Users\Lylia\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\DXQ4HODR\120px-Check_mark_23x20_02.svg[1].png**CHECK ALL THAT APPLY**  **CONSTITUTIONAL** | | | | | | | | | | |
| \_\_\_\_fever | | \_\_\_\_chills | | \_\_\_\_feeling poorly | | \_\_\_\_feeling tired | | \_\_\_\_weight gain | | \_\_\_\_weight loss |
| **EYES** | | | | | | | | | | |
| \_\_\_\_eye pain | | \_\_\_\_glasses/contacts | | \_\_\_\_spots before eyes | | \_\_\_\_vision changes | | \_\_\_\_dry eyes | | \_\_\_\_itchy eyes |
| **EAR/NOSE/THROAT** | | | | | | | | | | |
| \_\_\_\_ear aches | | \_\_\_\_loss of hearing | | \_\_\_\_nose bleeds | | \_\_\_\_sinus problems | | \_\_\_\_sore throat | | \_\_\_\_dental |
| **CARDIOVASCULAR** | | | | | | | | | | |
| \_\_\_\_chest pain | | \_\_\_\_slow heart rate | | \_\_\_\_fast heart rate | | \_\_\_\_leg swelling | | \_\_\_\_palpitations | |  |
| **RESPIRATORY** | | | | | | | | | | |
| \_\_\_\_shortness of breath | | \_\_\_\_wheezing | | \_\_\_\_cough | | \_\_\_\_respiratory distress in sleep | | \_\_\_\_shortness of breath lying flat | |  |
| **GASTROINTESTINAL** | | | | | | | | | | |
| \_\_\_\_abdominal pain | | \_\_\_\_vomiting | | \_\_\_\_nausea | | \_\_\_\_constipation | | \_\_\_\_diarrhea | | \_\_\_\_early satiety |
| \_\_\_\_heart burn | | \_\_\_\_black stool | | \_\_\_\_maroon colored stool | |  | |  | |  |
| **MUSCULOSKELETAL** | | | | | | | | | | |
| \_\_\_\_joint pain | | \_\_\_\_joint stiffness | | \_\_\_\_joint swelling | | \_\_\_\_limb swelling | | \_\_\_\_limb pain | |  |
| **INTEGUMENTARY** (SKIN) | | | | | | | | | | |
| \_\_\_\_acne | | \_\_\_\_breast discharge | | \_\_\_\_itching | | \_\_\_\_change in a mole | | \_\_\_\_breast pain | | \_\_\_\_breast lump |
| **NEUROLOGICAL** | | | | | | | | | | |
| \_\_\_\_confused | | \_\_\_\_memory loss | | \_\_\_\_dizziness | | \_\_\_\_headaches | | \_\_\_\_limb weakness | | \_\_\_\_difficulty walking |
| **PSYCHIATRIC** | | | | | | | | | | |
| \_\_\_suicidal | | \_\_\_\_sleep disturbance | | \_\_\_\_anxiety | | \_\_\_\_depression | | \_\_\_\_personality change | |  |
| **ENDOCRINE** | | | | | | | | | | |
| \_\_\_\_hair loss | | \_\_\_\_hot flashes | | \_\_\_\_heat/cold intolerance | | \_\_\_\_muscle weakness | | \_\_\_deepened voice | | \_\_\_\_feeling weak |
| \_\_\_\_dry skin | |  | |  | |  | |  | |  |
| **HEMATOLOGY/IMMUNOLOGY** | | | | | | | | | |  |
| \_\_\_\_easy bleeding | | \_\_\_\_seasonal allergies | | \_\_\_\_swollen glands | | \_\_\_\_easy bruising | |  | |  |