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 |

![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**

|  |  |  |
| --- | --- | --- |
| \_\_\_\_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 |  |  |