
Patient's Printed Name

Date of Birth

Date

ADVANCED OBSTETRICS & GYNECOLOGY

"Comprehensive Healthcare for Women"

In order to expedite your visit with us at your appointment and ensure that we address your issues appropriately, we ask that you please complete this form.

In a few words, tell us what brings you to our office:

Do you have any cultural or religious beliefs that might affect your care? No Yes - please explain below:

*Do you have any **chronic medical conditions**? No Yes - please list below:*

*Please list all of the **surgeries** you have had along with the month/year if known:*

Immunizations and most recent date:

- | | |
|---|-------------|
| <input type="checkbox"/> Flu Shot | Date: _____ |
| <input type="checkbox"/> Gardasil/HPV | Date: _____ |
| <input type="checkbox"/> Pneumonia | Date: _____ |
| <input type="checkbox"/> Tdap (Tetanus & Pertussis) | Date: _____ |
| <input type="checkbox"/> Tetanus | Date: _____ |
| <input type="checkbox"/> Shingrix | Date: _____ |

OB/GYN History:

Age of first menses: _____
Date of last menstrual period: _____
Number of Pregnancies: _____ Births _____
Miscarriages: _____
Terminations: _____
Sexual Orientation: _____

Pregnancy Details:

Date of Birth	Type of Delivery and how many weeks	Gender	Birth Weight	Hospital	Child's Name	Complications during Pregnancy and/or With Delivery
1						
2						
3						
4						
5						
6						

<i>Patient's Printed Name</i>	<i>Date of Birth</i>	<i>Date</i>
<i>Last Mammogram</i> <i>Date:</i> _____	<i>Last Pap Smear</i> <i>Date:</i> _____ <input type="checkbox"/> <i>Normal</i> <input type="checkbox"/> <i>Abnormal</i> <i>Any history of an abnormal pap?</i> <input type="checkbox"/> <i>No</i> <input type="checkbox"/> <i>Yes</i> <i>If yes, please detail the level of abnormality if known, date and any treatment:</i> _____ _____ _____	
<i>Last Bone Density Study</i> <i>Date:</i> _____		
<i>Last Colonoscopy</i> <i>Date:</i> _____		
<i>Last Pelvic Ultrasound:</i> <i>Date:</i> _____		
<i>Last Screening bloodwork</i> <i>Date:</i> _____		

It would be very helpful if you are able to obtain copies of your last testing and bring it with you to your appointment.

Allergies: *List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.*

<i>Allergy</i>	<i>Reaction</i>	
1. _____	_____	<input type="checkbox"/> <i>I have no known drug or food allergies.</i>
2. _____	_____	
3. _____	_____	
4. _____	_____	
5. _____	_____	

Medications: *Please list all the medications you are taking. Include prescribed medications and over-the-counter medications and supplements.*

	<i>Medication Name:</i>	<i>Strength:</i>	<i>Frequency Taken:</i>
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Family History – *please document any significant medical conditions among your BLOOD relatives:*

**Please include any heart disease, cancer (with age of diagnosis), hypertension, diabetes, osteoporosis, stroke, genetic disease, mental illness, arthritis, and any blood, colon, kidney or thyroid disease.*

<i>Relation</i>	<i>Alive ?</i>	<i>Current age or Age deceased</i>	<i>Significant Health Problem(s)*</i>
<i>Mother:</i>			
<i>Father:</i>			
<i>Brother/Sister:</i>			
<i>Brother/Sister:</i>			
<i>Brother/Sister:</i>			
<i>Maternal Grandmother:</i>			
<i>Maternal Grandfather:</i>			
<i>Paternal Grandmother:</i>			
<i>Paternal Grandfather:</i>			

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Relation	Alive ?	Current age or Age deceased	Significant Health Problem(s)*
Other:			
Other:			
Other:			
Other:			
Other:			

Smoking History: Never Former* Current Smoker*

* Please Age started: Age stopped: Quantity: Frequency:
complete _____ Packs _____ Cigarettes Daily Weekly

Do you exercise regularly? Never Occasionally _____ times/week Daily

Do you consider your diet: Well-balanced Fair Poor

Do you have any diet restrictions? No Yes, _____

Do you consume alcohol? No Yes (what and how often) _____

Caffeine Intake (coffee, teas, soda, etc.) None Yes, _____ cups/daily

Do you have any history of domestic violence? No Yes

Are you aware of how to prevent STD's? Yes No

Do you know how to do self-breast exams? Yes No

Were you born in the United States? Yes No, _____

Any recent travel out of the country (within the last year)? No Yes, _____

If you are experiencing any of the **symptoms** listed below, please check them off.

- | | | |
|--|---|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Mole changes |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Burning with urination | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Visual changes | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Leaking of urine | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Known tuberculosis exposure | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Irregular menses | <input type="checkbox"/> Bruising easily |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Swollen lymph nodes |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Breast discharge | <input type="checkbox"/> Environmental allergies |
| <input type="checkbox"/> Change in stools | <input type="checkbox"/> Breast lump | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Hives | |

Please circle any of the symptoms you have checked off above, if you would like to discuss them with your physician at your appointment.

Patient Signature