ADVANCED OBSTETRICS & GYNECOLOGY

"Comprehensive Healthcare for Women"

In order to expedite your visit with us today 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 the office today:

_____

_____

For you personally, has there been any new medical or surgical history since we last saw you?
☐ *No* ☐ *Yes,* _____

Has there been any new family history since your last visit?
☐ *No* ☐ *Yes,* _____

Since your last visit has there been any changes to your employment, social or lifestyle status?
☐ *No* ☐ *Yes,* _____

Have you traveled out of the country since your last visit?
☐ *No* ☐ *Yes,* _____

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

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

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

_____ _____ _____

Patient's Printed Name *Date of Birth* *Date*

_____

Patient Signature