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Patient Summary Sheet

We are currently switching our system to electronic medical records and are taking this opportunity to ensure that we have the most up-to-date information about our patients. We ask that you take the time to fill out this form with as much information as you can give. Please print this form and either fax it back to us at the above number or bring it in with you at your next visit. Thank you for being patient with us during this transition.

Name: _____ **Date of Birth:** _____

Surgical History (please check the applicable procedure and provide the date)

□ Appendectomy	Date: _____	□ Laparotomy	Date: _____
□ Breast Biopsy	Date: _____	□ LEEP	Date: _____
□ Breast Implants	Date: _____	□ Mastectomy	Date: _____
□ Cesarean Section	Date: _____	□ Myomectomy	Date: _____
□ Gall Bladder Removal	Date: _____	□ Oophorectomy	Date: _____
□ Dilation and Curettage	Date: _____	□ Ovarian Cystectomy	Date: _____
□ Ectopic Pregnancy	Date: _____	□ Thyroid Surgery	Date: _____
□ Endometrial Ablation	Date: _____	□ Tonsillectomy	Date: _____
□ Hysterectomy	Date: _____	□ Abdominal Hysterectomy	Date: _____
□ Hysteroscopy	Date: _____	□ Tubal Ligation	Date: _____
□ Laparoscopy	Date: _____	□ Other _____	Date: _____
□ Other _____	Date: _____	□ Other _____	Date: _____

Medications (please list all current medications, including birth control pills)

Medication	Dose	Start Date	Reason

Name: _____ Date of Birth: _____

Vaccines (please check yes or no and provide the date that you received the vaccination)

Flu (influenza)	□ Yes	□ No	Date: _____
HPV (human papilloma virus)	□ Yes	□ No	Date: _____
Tetanus	□ Yes	□ No	Date: _____
Tdap (tetanus + whooping cough)	□ Yes	□ No	Date: _____
Hepatitis B	□ Yes	□ No	Date: _____
Hepatitis C	□ Yes	□ No	Date: _____
MMR (measles, mumps, rubella)	□ Yes	□ No	Date: _____
Varicella (chickenpox) (vaccine or disease)	□ Yes	□ No	Date: _____
Varicella Zoster (shingles) vaccine	□ Yes	□ No	Date: _____
Meningococcal	□ Yes	□ No	Date: _____
Pneumococcal	□ Yes	□ No	Date: _____

Allergies (please list all known allergies and the reaction)

Drug/Allergen _____ Reaction _____
Drug/Allergen _____ Reaction _____
Drug/Allergen _____ Reaction _____
Drug/Allergen _____ Reaction _____

Past Medical History (please circle yes or no and give as much information as possible for your yes answers, including the date of diagnosis)

Abnormal Mammogram	Y / N	_____
Abnormal PAP	Y / N	_____
Anemia or Blood Disorder	Y / N	_____
Anesthesia complications	Y / N	_____
Asthma	Y / N	_____
BRCA Testing	Y / N	_____
Blood transfusion	Y / N	_____
Breast Cancer	Y / N	_____
Cancer - other	Y / N	_____
Cervical cancer	Y / N	_____
Depression	Y / N	_____
Endometriosis	Y / N	_____
GI Problems	Y / N	_____
Gestational diabetes	Y / N	_____
HIV	Y / N	_____
Headaches or Migraines	Y / N	_____
Heart Disease	Y / N	_____
Hepatitis	Y / N	_____

Name: _____ Date of Birth: _____

High Blood Pressure Y / N _____
High Cholesterol Y / N _____
Infertility Y / N _____
Kidney or Bladder Problems Y / N _____
Psychiatric Illness (ADHD, anxiety, bipolar, etc.) Y / N _____
STD (Chlamydia, gonorrhea, trich, herpes, etc.) Y / N _____
Seasonal Allergies Y / N _____
Thyroid Problems Y / N _____
Autoimmune (Lupus, RA, MS) Y / N _____
Eating Disorder Y / N _____
Diabetes, type 1 or type 2 Y / N _____
Other _____

Social History (please write in your answer or check the box where appropriate)

Country of birth: _____
Ethnic Background: □ Caucasian □ African American □ Latin □ Native American
□ Jewish □ Pacific Islander □ Asian □ Mediterranean
□ Eastern European □ Western European □ French Canadian
Occupation: _____
Education: □ Less than 8th Grade □ 10th grade □ 2 year college
□ 8th grade □ 11th grade □ 4 year college
□ 9th grade □ 12th grade □ Post Graduate
General stress level: □ Low □ Medium □ High
Exercise level: □ None □ Occasional □ Moderate □ Heavy
Diet: □ Regular □ Vegetarian □ Vegan □ Gluten free □ Specific □ Carbohydrate □ Cardiac
Marital status: □ Married □ Divorced □ Widowed
□ Single □ Separated □ Domestic Partner
Are you sexually active? □ Yes □ No
Sexual orientation: □ Heterosexual □ Homosexual □ Bisexual
Spouse or partner's name: _____
Children's names and dates of birth: _____
Smoking Status: □ Never a smoker □ Current every day smoker
□ Former smoker □ Current occasional smoker
Smoking - How much? _____ pack(s) per week OR _____ pack(s) per day
Alcohol Intake: □ Never _____ drink(s) per month OR _____ drink(s) per week
Do you use recreational drugs? □ Yes □ No If yes, please explain: _____
Hobbies and activities: _____

Name: _____ Date of Birth: _____

Health Maintenance

Do you.....

take folic acid or a multivitamin? □ Yes □ No
have guns present in your home? □ Yes □ No
wear seat belts routinely? □ Yes □ No
use sunscreen routinely? □ Yes □ No
have smoke alarms in your home? □ Yes □ No
have an advance directive? □ Yes □ No
perform monthly self-breast exams? □ Yes □ No

Family History

Does anyone in your family have any of the following problems? If so, please list who and their age when they were diagnosed (if known).

□ breast cancer _____ □ gyn cancer _____
□ skin cancer _____ □ other cancer _____
□ colorectal cancer/polyps _____ □ high blood pressure _____
□ diabetes _____ □ heart disease/stroke _____
□ thyroid disease _____ □ osteoporosis _____
□ genetic disorder _____ □ other _____
□ other _____ □ other _____

GYN History (please write in your answer or check the box where appropriate)

Age at menarche (first period): _____
Frequency of cycle (example: every 28 days): _____
Duration of flow (example: lasts 3-5 days): _____
Flow: □ Normal □ Light □ Heavy
Do you have a monthly period? □ Yes □ No
Cramps: □ No □ Mild □ Moderate □ Severe
If post-menopausal, age at menopause: _____
Hormone replacement therapy use: □ Never □ Short-term □ Past use □ Current user
Date of last PAP smear: _____
History of abnormal PAP? □ Yes □ No
History of cervical biopsy? □ Yes □ No
History of cervical procedure? □ Yes □ No
Sexually active? □ Yes □ No
Sexual preference: □ Heterosexual □ Homosexual □ Bisexual
Sexual partner: □ Husband □ Long-term monogamous relationship □ New partner
Total partners since last GYN exam: _____
Current birth control method: □ Birth control pills □ Sterilization □ Tubal ligation □ IUD

Name: _____ Date of Birth: _____

□ Condoms □ Partner Vasectomy □ Depo-Provera □ Vaginal Ring □ Implant
□ Abstinence □ Hysterectomy □ Withdrawal □ Spermicide □ Patch
□ Diaphragm □ Fertility Issues □ Pregnant □ Breastfeeding □ Sponge
□ Ablation □ Cervical Cap □ Menopause □ Seeking Pregnancy
□ Multiple Methods □ Fertility Awareness Method □ Emergency Contraception
□ Other: _____

History of STD or PID? □ Yes □ No
Date of last Mammogram: _____
History of abnormal mammogram? □ Yes □ No
Date of last DEXA (bone density scan): _____

Other providers and specialists that you see (include name and telephone number if known)

Primary Care Provider: _____
Specialist: _____
Specialist: _____
Specialist: _____

Preferred Pharmacy: _____

Past Pregnancies

Date	Gestational Age	Labor Length	Weight	Gender	Delivery Type	Type of Anesthesia	Provider who delivered