Bluefield Women's Center, P.C.

Obstetrics and Gynecology

Name_____ Date_____ Date of Birth_____

Well Woman Update: (Please provide dates where applicable) Primary Care Provider_____

Last Pap smear_____
Last mammogram_____
Last bone density_____
Last colonoscopy_____

HPV/Gardisil Vaccine series completed?_____YES _____NO
Have you had the Hepatitis B series? _____YES _____NO

Any abnormal Pap smears? _____YES _____ NO
Cervical Dysplasia(precancerous cells of the cervix)?
_____YES _____NO
If yes, any treatment? Dates:
LEEP _____
Laser _____
Cryo(freezing)_____
Cone Biopsy _____

Medical History: Do you now have or have you ever had:

____Asthma
____Bleeding Disorder
____Blood transfusion
____Bone/Joint Disease
____Cancer(type?)_____
____Chicken pox/Shingles
____Chlamydia
____Deep Vein Thrombosis
____Depression/Anxiety
____Diabetes
____Cholesterol
____Endometriosis
____Fibroids
____GERD/Reflux
____G.I. Illness
____Heart Disease
____Hepatitis A
____Hepatitis B
____Hepatitis C
____Herpes
____Irritable Bowel
____HIV
____HPV/genital warts
____High Blood Pressure
____Thyroid Disease
____Liver Disease
____Migraines
____Osteopenia
____Osteoporosis
____Seizures
____Syphilis
____Tuberculosis

Other:_____

Family History:

ILLNESS	MOTHER	FATHER	BROTHER	SISTER	MAT. GM	MAT. GF	PAT. GM	PAT. GF	OTHER RELATIVE
CANCER TYPE									
DIABETES									
DVT									
HEART DISEASE									
OSTEOPOROSIS									

MENSTRUAL CYCLE:

Date of last period_____ Age at first period_____ If menopausal, age of menopause_____
How often do you get your period? Every_____days, lasting_____days.
Are your cycles? ____Regular ____Irregular
Are you sexually active? ____Never ____Not currently ____Yes

Method of contraception:

____None ____Vasectomy ____Rhythm Method ____Implanon ____Pill ____Tubal Ligation
____Depo Provera ____Condoms ____Nuva Ring ____Mirena IUD ____ParaGuard IUD ____Essure
____Patch ____Other

Signature:_____ **Date:**_____

Obstetrical History

Please list all pregnancies, including miscarriages, abortions, and ectopic pregnancies. Please include full birthdate.

Type: vaginal or C-section **Anesthesia:** epidural, local, general, spinal

Complications examples: preterm labor, diabetes, bleeding, hypertension, postpartum depression.

PAST PREGNANCIES:

Birthdate	Weeks	Length of Labor	Baby's Weight	Sex	Type of Delivery	Anesthesia	Complications	Location

Social History

Occupation_____ Are you? ____Single ____Married ____Divorced ____Widowed

Tobacco Use ____Never ____Current___# of Cigarettes per day ____Former, Quit ____ years ago

Any alcohol use? ____No ____Yes, average number of drinks per week_____

Do you use abuse street drugs or narcotics? ____No ____Yes, type used and last use _____

How many times and how long per week do you exercise?_____

Any history of violence or abuse in your current household or in your past? ____No _____Yes

Do you have any cultural or religious considerations that need special attention? ___No ____Yes, explain_____

Surgeries

Date of Procedure	Type of Procedure	Location

Signature:_____ **Date:**_____

Please List All Allergies:

Name of Medication	Reaction

Medication List:

Name of Medication	Dose/Strength	How Often Taken

NAME OF PHARMACY(name, address, number)_____

Signature:_____ **Date:**_____

Patient History and Review of Systems

Name:_____ Date:_____

Check if you have the following:

GENERAL
____Fever
____Chills
____Sweats
____Anorexia
____Fatigue
____Weakness
____Malaise
____Weight Loss
____Sleep Disorder

EYES
____Vision Loss-1 Eye
____Double Vision
____Eye Irritation
____Vision Loss-Both Eyes
____Blurring
____Eye Pain
____Halos
____Eye Discharge
____Light Sensitivity

EARS, NOSE AND THROAT
____Ringing in Ears
____Ear Discharge
____Earache
____Decreased Hearing
____Nasal Congestion
____Nosebleeds
____Difficulty Swallowing
____Hoarseness
____Sore Throat

CARDIOVASCULAR
____Diff. Breathing at Night
____Near Fainting
____Chest Pain or Discomfort
____Racing/Skipping Heart Beats
____Fatigue
____Lightheadedness
____Shortness of Breath with Exertion
____Palpitations
____Swelling of Hands or Feet
____Difficulty Breathing Lying Down
____Fainting
____Leg Cramps with Exertion
____Bluish Color Lips/Nails
____Weight Gain

RESPIRATORY
____Breathing Disturbs Sleep
____Cough
____Shortness of Breath
____Coughing up Blood
____Chest Discomfort
____Wheezing
____Excessive Sputum
____Excessive Snoring

GASTROINTESTINAL
____Excessive Appetite
____Loss of Appetite
____Indigestion
____Vomiting Blood
____Nausea
____Vomiting
____Yellow Skin Color
____Gas
____Abdominal Pain
____Abdominal Bloating
____Hemorrhoids
____Diarrhea
____Change in Bowel Habits
____Constipation
____Dark, Tarry Stools
____Blood in the Stools

GENITOURINARY
____Foul Urinary Discharge
____Blood in Urine
____Urinary Frequency
____Inability to Empty Bladder
____Urinary Urgency
____Kidney Pain
____Trouble Starting Stream
____Painful Urination
____Nighttime Urination
____Inability to Control Bladder
____Genital Sores
____Lack of Sexual Drive
____Erectile Dysfunction
____Excessively Heavy Periods
____Missed Periods
____Unusual Urinary Color
____Abnormal Vaginal Bleeding
____Pelvic Pain

MUSCULOSKELETAL
____Muscle Cramps
____Joint Pain
____Joint Swelling
____Joint Fluid Present
____Back Pain
____Stiffness
____Muscle Weakness
____Arthritis
____Gout
____Loss of Strength
____Muscle Aches

DERMATOLOGICAL
____Excessive Perspiration
____Night Sweats
____Suspicious Lesions
____Changes in Nail beds
____Dryness
____Poor Wound Healing
____Unusual Hair Distribution
____Skin Cancer
____Itching
____Changes in Skin Color
____Flushing
____Rash

NEUROLOGICAL
____Diff. with Concentration
____Poor Balance
____Headaches
____Coordination Difficulty
____Numbness
____Inability to Speak
____Falling Down
____Tingling
____Brief Paralysis
____Visual Disturbance
____Seizures
____Weakness
____Sensation of Room Spinning
____Tremors
____Fainting
____Excessive Daytime Sleepiness
____Memory Loss

PSYCHOLOGICAL
____Sense of Great Danger
____Anxiety
____Thoughts of Suicide
____Mental Problems
____Depression
____Thoughts of Violence
____Frightening Visions/Sounds

ENDOCRINE
____Excessive Hunger
____Cold Intolerance
____Heat Intolerance
____Excessive Urination
____Excessive Thirst
____Weight Change

HEMATOLOGY
____Enlarged Lymph Nodes
____Bleeding
____Skin Discoloration
____Abnormal Bruising
____Fevers

ALLERGY
____Persistent Infections
____Hives or Rash
____Seasonal Allergies
____HIV Exposure

BREAST
____Left Breast Lump
____Right Breast Lump
____Nipple Discharge
____Bloody Discharge from Nipple
____Breast Pain
____Abnormal Mammogram
____Breast Enlargement