

Name: _____ Date of Birth: _____

Date of LMP: _____

Current Medications (include hormones, herbs, vitamins, nonprescription medicine)

Name and Dosage		Name and Dosage	
1.		4.	
2.		5.	
3.		6.	

Allergies (Please include all drug allergies)

1.		3.	
2.		4.	

What is your problem today: late for menses, irregular menses, abnormal uterine bleeding, positive home pregnancy test, negative home pregnancy test

Are your periods regular (28-30 days)? **Yes No** If no, every _____ days

Have you used the pill or Depo-Provera recently? **Yes No**

Was your last period normal? **Yes No**

Did you do a pregnancy test when you thought you were late? **Yes No When?** _____

Any problems thus far this pregnancy? (circle or write below)

Nausea Weight gain Weight Loss Breast Tenderness Pain Cramping Vomiting

Other:

System Review
Please answer each category

General	None	Fever	Chills	Sweats	Loss of Appetite	Fatigue
		Generally feel badly	Weight loss			
ENT	None	Earache	Hoarseness	ringing In ears	Decreased hearing	
		Nasal congestion	Nosebleeds	Sore throat	Difficulty swallowing	
Heart	None	Chest pains	Palpitations	Fainting Spells	Difficulty breathing when lying flat	
		Out of breath exertion	Short of breath at night		Swelling in legs	
Lung	None	Cough	Shortness of breath		Excessive sputum	
Gastro	None	Nausea	Vomiting	Diarrhea	Constipation	
		Change in bowel habits	Abdominal pain	Black/tarry Stools	Jaundice	Vomiting blood
Urinary	None	Leaking urine with cough or sneeze		Leaking urine without cough or sneeze		
		Burning with urination		Blood in urine	Urinary frequency	
Breasts	None	Pain	Lump	Discharge		
GYN	None	Vaginal discharge with itching		Vaginal discharge with odor		
		Other vaginal discharge		Pelvic pain	Abnormal vaginal bleeding	
		Heavy vaginal bleeding		Missed periods	Irregular menses	
Ortho	None	Back pain	Joint swelling	Muscle cramps		
		Muscle weakness	Stiffness	Arthritis		
Skin	None	Rash	Itching	Dryness		
Neuro	None	Sensation of room spinning		Weakness	Tingling	Seizures
		Fainting spells		Tremors		
Psych	None	Depression		Anxiety	Memory loss	Mental disturbance
		Suicidal thoughts		Hallucinations		
Endocrine	None	Cold intolerance		Heat intolerance		Excessive thirst
		Excessive hunger		Excessive amounts of urine		
		Significant weight loss		Significant weight gain		

Since Your Last Visit:		Yes	No	Please describe:
Have you been diagnosed with a new medical problem?				
Have you had any surgeries?				
Have you been diagnosed with a new medication allergy?				
Do you have any new family history?				

Menstrual History		Yes	No
Are you menopausal?			
Have you had a hysterectomy?			
Are you currently late for your period?			
Are you currently pregnant?			
What was your age at your first menstrual period?			
Date of your last menstrual period:			
Are your periods regular (28-30 days)?			
If No what is the interval between your periods? (Number of days)			
How many days of bleeding do you have?			
How many heavy days?			
Do you have pain with your period?			
If Yes- how bad is that pain?	Minimal Mild Moderate Severe		
Do you have a problem with heavy bleeding?			
Do you bleed onto your clothes or bedding?			
Do you bleed after intercourse?			
Do you have bleeding between your periods?			
If Yes- how bad is that bleeding?	Light Medium Heavy		
Occurring?	Early Mid-cycle Late Just prior to menses Random		
Contraception		Yes	No
Are you in a sexual relationship?			
Do you have pain with intercourse?			
Are you trying to become pregnant?			
Do you have questions about sexual function, contraception, or infections?			
Permanent Sterilization Method:	Essure Tubal ligation Vasectomy Hysterectomy None		
What type of contraception do you currently use?	None Essure Tubal ligation Hysterectomy		
	Abstinence Rhythm Method Male withdrawal Condoms Spermicides Diaphragm		
	Norplant Pills Patch Ring Shot IUD-Paragard IUD-Mirena Implanon		
What type of contraception have you previously used?	None Abstinence Rhythm Method		
	Male withdrawal Condoms Spermicides Diaphragm Norplant Pills Patch		
	Ring Shot IUD-Paragard IUD-Mirena Implanon		

PATIENT HISTORY Name: _____ Date of Birth: _____

Personal History of Past Illness

Major Illness	Yes (Date)	Major Illness	Yes (Date)
Anemia		Glaucoma	
Arthritis/Joint pain		Headaches (chronic only)	
Asthma		Heart Disease	
Back problems		Hepatitis/Yellow Jaundice/Liver Disease	
Blood Clots in lungs or legs		High Blood Pressure	
Blood Transfusions		High Cholesterol	
Bowel Problems		HIV/Aids	
Broken bones		Kidney Infections/Kidney Stones	
Cancer		Pneumonia/Lung Disease	
Cataracts		Reflux/Hiatal Hernia/Ulcers	
Chickenpox		Rheumatic Fever	
Collagen Vascular Disease (Lupus)		Seizures/Convulsions/Epilepsy	
Depression or Anxiety (circle)		Sexually Transmitted Disease	
Diabetes		Stroke	
Eating Disorders		Thyroid Disease	
Gallbladder Disease		Tuberculosis	
Other			

GYN History

Problem	Yes	No	Problem	Yes	No
Abnormal hair growth			Infertility		
Abnormal Bleeding			Ovarian Cyst		
Abnormal Pap Smear			Osteoporosis		
Breast Problems			Sexual Problems		
Cyst of Vulva			Sexually transmitted disease		
DES Exposure			Uterine Abnormality		
Endometriosis			Urinary Leakage		
Fibroid Uterus			Vaginal/Vulvar Infection		

Surgeries

Surgery	Yes	No	Date/Comments
Abdominal Surgery			
C-Section Delivery			
Dilation & Curettage (D & C)			
Hysterectomy			
Hysteroscopy (out patient)			
Laparoscopy (out patient)			
Vaginal Surgery			
Bartholin Glands Surgery			
Other (Please List):			

Social History

Preferred Name:	PCP:	Occupation:
Number of people in household:	Single Married Widowed Divorced Separated Living w/ partner	
Education (last grade completed):	Name of significant other:	
Children's Names:		
Seat Belt Use: Always Frequently Occasionally Never		
Occupational Risks: None Biohazard Chemical Physical Labor		
How many days per week do you exercise?	How many packs of cigarettes per day do you smoke?	
How many times per week do you drink alcohol?		
Do you use any of the following? cocaine narcotics marijuana hallucinogens		

Family History- Please check those that apply

Illness	Mother	Father	Sibling	Child	Maternal Grandparent	Paternal Grandparent	Other
Breast Cancer							
Colon Cancer							
Ovarian Cancer							
Alzheimer's Disease							
Birth Defects							
Blood Clots in lungs or legs							
Diabetes							
Drinking or Drug problems							
Endometriosis							
Fibroids							
Heart Disease							
Hepatitis							
High Blood Pressure							
High Cholesterol							
HIV/AIDS							
Mental Illness/Depression							
Osteoporosis							
Stroke							
Tuberculosis							
Other							

Obstetric History

#Total Pregnancies						
	# Full Term		#Premature		#Elective Abortion	
# Miscarriage	#Ectopic		#Multiples		#Living	
Pregnancy #	1	2	3	4	5	6
Pregnancy Outcome <small>F=Full term, P=Premature, M=Miscarriage</small>						
Delivery Date						
Weeks at Delivery						
Length of labor (hrs.)						
Epidural/Anesthesia						
Delivery Type <small>V=Vaginal, C=C-section</small>						
Did you have Pre-term Labor?						
Delivery Location						
Who delivered your baby?						
Baby weight?						
Baby Sex?						
Baby Name?						
Complications	Please check any that apply					
Gestational Diabetes						
Macrosomia						
Multiple Gestation						
Post Dates						
Post partum hemorrhage						
Pre-eclampsia						
Preterm Delivery						
Other Complications						