**Patient Identification:**

Sagar Y. Patel M.D. Obstetrics & Gynecology

Date__________

Patient's Name: ________________________________ Date of Birth: _____/_____/_____ Age________

Address: ________________________________ Marital Status: ❑ S ❑ M ❑ D ❑ Sep ❑ W

________________________________ Race: ________________ Religion:________________________________

Home Telephone: ( )______________________ Education: _____Years Occupation:________________________________

Work Telephone: ( )______________________ Employer: ________________________________

Cell Telephone: ( )______________________ Referring Physician: ________________________________

Type of Insurance:______________________ Primary Physician: ________________________________

Policy #:______________________________ Heard Of Practice From:________________________________

## II. Reason For Seeing Doctor:

## III. Medical History (Check the appropriate box)

| Have you or any members of your family had: | You | Your Family |
|---|---|---|
| 1. High Cholesterol | ❑ | ❑ |
| 2. Heart Disease | ❑ | ❑ |
| 3. Rheumatic Fever | ❑ | |
| 4. High Blood Pressure | ❑ | ❑ |
| 5. Asthma | ❑ | |
| 6. Tuberculosis | ❑ | |
| 7. Diabetes | ❑ | ❑ |
| 8. Thyroid Problems | ❑ | ❑ |
| 9. Liver Disease | ❑ | |
| 10. Stomach, Bowel or Gall Bladder Problems | ❑ | |
| 11. Kidney or Bladder Problems | ❑ | |
| 12. AIDS (HIV) | ❑ | ❑ |
| 13. Hepatitis (type_____) | ❑ | ❑ |
| 14. Anemia or Blood Disorder | ❑ | ❑ |
| 15. Blood Transfusion | ❑ | |
| 16. Allergies | ❑ | |
| 17. Breast Problems | ❑ | ❑ |
| 18. Cancer | ❑ | ❑ |
| 19. Infertility | ❑ | |
| 20. Female or Sexual Problems | ❑ | |
| 21. Chlamydia | ❑ | |
| 22. Gonorrhea | ❑ | |
| 23. Herpes (HSV) | ❑ | |
| 24. Syphilis | ❑ | |
| 25. Birth Defects or Inherited Diseases | ❑ | ❑ |
| 26. Sexual Abuse or Domestic Violence | ❑ | ❑ |
| 27. Other Medical Problems | ❑ | ❑ |
| 28. **No Known Medical Problems** | ❑ | ❑ |

## IV. Hospitalizations

Please list those operations or serious illnesses that you have had which required hospitalization. If you have had more than six, check this box. ❑ **Do Not Include Pregnancies Here**

| Month / Year | Illness or Operation | Attending Physician's Name | Complications No | Complications Yes |
|---|---|---|---|---|
| | | | ❑ | ❑ |
| | | | ❑ | ❑ |
| | | | ❑ | ❑ |
| | | | ❑ | ❑ |
| | | | ❑ | ❑ |
| | | | ❑ | ❑ |
| | | | ❑ | ❑ |

## V. Pregnancy History (Complete All Information)

| # of Pregnancies | # of Premature Births | # of Miscarriages | # of Induced Abortions | # of Living Children |
|---|---|---|---|---|
| | | | | |

| # of Term Births | Born Month / Year | Baby's Sex | Weight at Birth | Weeks Pregnant (Term=40 Wks) | Hours in Labor | Type of Delivery | Type of Anesthesia | Complications No | Complications Yes |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | lbs oz | | | | | ❑ | ❑ |
| 2 | | | lbs oz | | | | | ❑ | ❑ |
| 3 | | | lbs oz | | | | | ❑ | ❑ |
| 4 | | | lbs oz | | | | | ❑ | ❑ |
| 5 | | | lbs oz | | | | | ❑ | ❑ |
| 6 | | | lbs oz | | | | | ❑ | ❑ |
| 7 | | | lbs oz | | | | | ❑ | ❑ |

Please answer the following questions by putting an (x) in the box next to the word Yes or No, except where you are asked for specific information.

If a question does not apply to you, skip it and go on to the next one.

If for any reason you can't or don't want to answer a question, put a large dot (●) in the Yes or information space.

## Menstruation

*If you have not yet begun to menstruate, please begin with question 12.*

| | Question | Answer |
|---|---|---|
| 1. | How old were you when you first began menstruating? | ________ years old |
| 2. | What was the first day of your last menstrual period? | ____/____/______ (mm/dd/yy) |
| 3. | Are you past menopause, or have you had a hysterectomy? | ❑ Yes ❑ No |
| 4. | *If Yes: Have you noticed any vaginal bleeding since?* ***(Please skip to question 12)*** | ❑ Yes ❑ No |
| 5. | Was your last menstrual period normal? | ❑ Yes ❑ No |
| 6. | How many days pass between the first day of each period? | _______ days pass |
| 7. | How long do your periods last? | _______ days |
| 8. | On your heaviest day, how many pads and/or tampons do you use? | _________ pads and/or _________ tampons at most |
| 9. | Are your periods usually painful? | ❑ Yes ❑ No |
| 10. | *If Yes: Is the pain generally mild, moderate or severe?* | ❑ Mild Pain ❑ Moderate Pain ❑ Severe Pain |
| 11. | *How do you treat your pain?* | Treat with ____________________________ |

## Gynecology

| | Question | Answer |
|---|---|---|
| 12. | Do you examine your breasts at least once a month? | ❑ Yes ❑ No |
| 13. | Have you noticed any discharge from your breasts? | ❑ Yes ❑ No |
| 14. | Have you noticed any change in the size of your breasts? | ❑ Yes ❑ No |
| 15. | Have you noticed any lumps or pain in your breasts? | ❑ Yes ❑ No |
| 16. | Have you ever had a mammogram? | ❑ Yes ❑ No |
| 17. | *If Yes: Write in the month and year of your last test* | ______ month ________ year of last mammogram |
| 18. | Have you had recurrent bladder infections? | ❑ Yes ❑ No |
| 19. | Are you bothered by frequent or painful urination? | ❑ Yes ❑ No |
| 20. | Do you have recurrent middle back pain? | ❑ Yes ❑ No |
| 21. | Have you had any recent vaginal itching or discharge? | ❑ Yes ❑ No |
| 22. | Have you ever had any infection in your tubes or ovaries? | ❑ Yes ❑ No |
| 23. | Have you ever had a Pap test? | ❑ Yes ❑ No |
| 24. | *If Yes: Write in the month and year of your last test* | ______ month ________ year of last Pap test |
| 25. | Have you ever had abnormal results from a Pap test? | ❑ Yes ❑ No |
| 26. | Did your mother ever take DES or any other hormones when she was pregnant with you? | ❑ Yes ❑ No |
| 27. | Are you currently having sexual intercourse? | ❑ Yes ❑ No |
| 28. | *If Yes: Do you have one or many partners?* | ❑ One ❑ Many |
| 29. | *Do you have pain with sexual intercourse?* | ❑ Yes ❑ No |
| 30 | Do you use birth control on a regular basis? | ❑ Yes ❑ No |
| 31. | What forms of birth control have you or your partner used? | ❑ Oral (list type_________________)<br>❑ IUD ❑ Diaphragm ❑ Norplant ❑ Patch<br>❑ Sponge ❑ Spermicide ❑ Condoms<br>❑ Other __________________ |
| 32. | Do you have any questions about birth control? | ❑ Yes ❑ No |
| 33. | Have you ever had complications with any type of birth control? | ❑ Yes ❑ No |
| 34. | Do you have any questions about sexually transmitted diseases? | ❑ Yes ❑ No |
| 35. | Are there any questions or problems about sex that you would like to discuss? | ❑ Yes ❑ No |
| 36. | Have you ever had any difficulty becoming pregnant? | ❑ Yes ❑ No |

## Substance Use

| | |
|---|---|
| 37. Do you smoke cigarettes? | ❑ Yes ❑ No |
| 38. *If Yes: How many packs per day, and for how many years, do you smoke?* | _____ packs per day _____ years |
| 39. Do you drink alcohol? | ❑ Yes ❑ No |
| 40. *If Yes: What kind of alcohol do you consume?* | ❑ Beer ❑ Wine ❑ Mixed Drinks ❑ Other |
| 41. *How much alcohol do you consume in a week?* | _____ glasses per week |
| 42. How much caffeine do you consume in a typical day? | ❑ None ❑ 1-2 cups ❑ 3-4 cups ❑ 5 or more cups |
| 43. Do you take any street drugs? | ❑ Yes ❑ No |
| 44. *If Yes: What type of street drugs do you use?* | __________ type of street drugs taken |
| 45. *How much do you use in one day?* | __________ amount per day |

## Medication

Please list any medications, including the dose and frequency, that you are currently taking:

## Allergies

Please list any allergies to medications you have, including the associated reactions:

## Review of Symptoms (ROS)

Please check any pertinent symptoms, otherwise check "Negative" meaning no symptoms.

| Category | | | | | |
|---|---|---|---|---|---|
| 1. Constitutional | ❑ Negative | ❑ Weight Loss | ❑ Weight Gain | | |
| | ❑ Fever | ❑ Fatigue | ❑ Other | Tallest Height ________________ | |
| 2. Eyes | ❑ Negative | ❑ Vision Change | ❑ Glasses / Contacts | | |
| | ❑ Other | | | | |
| 3. Ear, Nose, and Throat | ❑ Negative | ❑ Ulcers | ❑ Sinusitis | | |
| | ❑ Headache | ❑ Hearing Loss | ❑ Other | | |
| 4. Cardiovascular | ❑ Negative | ❑ Orthopnea | ❑ Chest Pain | ❑ Difficulty Breathing on Exertion | |
| | ❑ Edema | ❑ Palpitation | ❑ Other | | |
| 5. Respiratory | ❑ Negative | ❑ Wheezing | ❑ Hemoptysis | | |
| | ❑ Shortness of Breath | | ❑ Cough | ❑ Other | |
| 6. Gastrointestinal | ❑ Negative | ❑ Diarrhea | ❑ Bloody Stool | ❑ Nausea / Vomiting /Indigestion | |
| | ❑ Constipation | ❑ Flatulence | ❑ Pain | ❑ Fecal Incontinence | ❑ Other |
| 7. Genitourinary | ❑ Negative | ❑ Hematuria | ❑ Dysuria | | ❑ Urgency |
| | ❑ Frequency | ❑ Incomplete Emptying | | | ❑ Incontinence |
| | ❑ Dyspareunia | ❑ Abnormal or Painful Periods | | | ❑ PMS |
| | ❑ Abnormal Vaginal Bleeding | | ❑ Abnormal Vaginal Discharge | | ❑ Other |
| 8. Musculoskeletal | ❑ Negative | ❑ Muscle Weakness | | | |
| | ❑ Other | ❑ Muscle or Joint Pain | | | |
| 9a. Skin | ❑ Negative | ❑ Rash | ❑ Ulcers | | |
| | ❑ Dry Skin | ❑ Pigmented Lesions | | ❑ Other | |
| 9b. Breast | ❑ Negative | ❑ Mastalgia | | | |
| | ❑ Discharge | ❑ Masses | ❑ Other | | |
| 10. Neurologic | ❑ Negative | ❑ Syncope | ❑ Seizures | ❑ Numbness | |
| | ❑ Trouble Walking | | ❑ Severe Memory Problems | | ❑ Other |
| 11. Psychiatric | ❑ Negative | ❑ Depression | ❑ Crying | | |
| | ❑ Severe Anxiety | ❑ Other | | | |
| 12. Endocrine | ❑ Negative | ❑ Diabetes | ❑ Hypothyroid | ❑ Hyperthyroid | |
| | ❑ Hot Flashes | ❑ Hair Loss | ❑ Heat / Cold Intolerance | | ❑ Other |
| 13. Hematologic / Lymphatic | ❑ Negative | ❑ Bruises | | | |
| | ❑ Bleeding | ❑ Adenopathy | ❑ Other | | |

**Physician Use Only**