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

Obstetrical and Gynecological Information

Please complete the following

Age at first cycle: _____ Are your cycles: Regular Irregular
How long do your cycles last? _____ Menstrual flow: Light Moderate Heavy
First day of last menstrual period: _____
Are you currently sexually active? Yes No Age of onset of sexual activity _____
Number of sexual partners: (circle) less than 5 greater than 5
Partner change in the past year: Yes No
Current birth control method: _____
History of STD: No Yes (circle) HPV Herpes Gonorrhea Chlamydia Trichomonas
HIV/AIDS Other: _____
Have you received the Gardasil Series (HPV vaccine)? No Yes Did not complete

Age of Menopause: _____ Post-menopausal bleeding: No Yes If yes, when: _____

Comments: _____

_____

Have you had any of the following? If yes, please list dates:

Colonoscopy _____ Dexascan _____ Flu Vaccine _____

Mammogram _____ Vitamin D Level _____ Tdap _____

Past pregnancy history

Total number of pregnancies _____Living children _____ Miscarriage(s)_____

Abortion(s)_____ Vaginal deliveries_____ C-sections_____ Premature Births (<37wks) _____

Did you have any of the following pregnancy complications? Circle all that apply

HIGH BLOOD PRESSURE GESTATIONAL DIABETES PREECLAMPSIA OTHER

Comments: _____

_____

Patient's Medical and Family History

Please circle any past and/or present medical problems as they pertain to you.

GENERAL
Birth Defect
Describe: _____
Cancer
Describe: _____
Diabetes
Anxiety
Depression
Epilepsy/seizures
HIV/AIDS
Thyroid Disease

BLOOD
Anemia
Blood Clot
Blood Transfusion
Bleeding Disorders
Factor V Leiden

CARDIOVASCULAR
Heart Attack
Heart Problems
High Blood Pressure
Pacemaker
Stroke

GI/GU
Bowel Disorder
Bladder Disorder
Gallbladder problems
GI bleed
Hepatitis/jaundice
Hernia
Kidney problems
Liver problems
Reflux disease
Ulcer

RESPIRATORY
Asthma
Lung disease
Pneumonia
Tuberculosis

GYN
Infertility
Endometriosis
Ovarian Cysts
PCOS
Heavy periods
Painful periods
Pain with intercourse
Abnormal pap smear
Year _____
Treatment _____
Last Pap Smear _____

Please circle any past and/or present medical problems as they pertain to your father/mother, siblings, aunts, uncles and grandparents and indicate relationship to you

GYN problems: PCOS Infertility Endometriosis Pelvic Pain _____
Bleeding tendencies or bleeding disorders such as Factor V Leiden: _____
Cancer: _____
Diabetes: _____
Heart problems/High Blood Pressure: _____
Thyroid Disease: _____
Problems with anesthesia: _____

REVIEW OF SYSTEMS: Please circle any symptoms that apply to your current health.

GENERAL
Fatigue
Fever/chills
Change in sleep habits
Unplanned weight change

EYES, EARS, NOSE, THROAT
Blurry or double vision
Eye or Ear pain
Hearing loss
Nosebleeds

CARDIAC
Chest pain/discomfort
Heart murmur
Irregular heartbeat
Irregular heartbeat
Leg swelling

RESPIRATORY
Cough
Shortness of breath
Wheezing

GI/GU
Belly pain
Blood in urine
Blood in stool
Constipation
Diarrhea
Heartburn
Incontinence (bladder)
Incontinence (bowels)
Nausea/vomiting
Urinary frequency

NEUROLOGICAL
Anxiety
Depression
Dizzy/Fainting
Mood Swings
Headaches

MUSCULOSKELETAL
Back pain
Muscle weakness
Muscle pain
Joint pain

SKIN
Changes
Lesions/Moles
Dryness
MRSA infection
VRE infection

BREASTS
Mass
Nipple Discharge
Pain
Rash

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

PAST MEDICAL & SURGICAL HISTORY

Please list any Allergies

Allergy:_____Reaction: _____Allergy: _____ Reaction: _____
Allergy:_____Reaction: _____Allergy: _____ Reaction: _____
Allergy:_____Reaction: _____Allergy: _____ Reaction: _____

Please list any Past Surgeries

_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____

Please list any Chronic Illnesses

_____ Year Diagnosed: _____
_____ Year Diagnosed: _____
_____ Year Diagnosed: _____
_____ Year Diagnosed: _____
_____ Year Diagnosed: _____
_____ Year Diagnosed: _____

Social History

Marital Status: Single Married Divorced Widowed In Relationship

Do you currently smoke? No Yes How many years? _____Packs per day _____ Desire to quit Y N

Do you consume alcohol? Socially Non Drinker Heavy Drinker Alcoholic Recovering Alcoholic

Do you exercise? None Occasional (1-3 times per week) Regular (4-7 times per week)

Past or current illegal drug use? No Yes Please list: _____

Piercings or implanted devices? No Yes If yes, where? _____