ROSWELL OB/GYN, LLC
www.roswellobgyn.org

PATIENT VISIT

Name: ____________________ Age: ________ Today's Date: ____________________
Preferred Name: ____________________
What is the reason for your appointment today? If it is a problem please describe the symptoms or the specific problem:

____

____

____

Do you see a Primary Care Doctor every year for a physical and bloodwork? If yes, Name: ____________________

OB HISTORY

1. How many times have you been pregnant? .... _________
2. How many miscarriages have you had? .... _________
3. How many abortions have you had? .... _________
4. Have you had any Tubal/Ectopic pregnancies? .... _________
5. How many vaginal deliveries have you had? .... _________
6. How many Cesarean Sections have you had? .... _________
7. Have you had any premature deliveries? .... _________
8. Have you had any babies weighing less than 5 lb. 8 oz. at birth? .... _________
9. How many full term deliveries? .... _________
10. Have you had any twin births? .... _________
11. Did you have any complications with your pregnancies? .... _________
    If yes, list: ____

    ____

GYN HISTORY

1. Are you sexually active? .... ____YES .... ____NO
1a. Have you been sexually active? .... ____YES .... ____NO
2. Do you have pain with intercourse? .... ____YES .... ____NO
3. What type of contraception are you currently using? (Circle Below)
   Pills Tubal Ligation Condoms Withdrawal Depo Provera IUD
   Foam Vasectomy Diaphragm Implants Other
4. **What type of contraception have you used in the past? (Circle Below)**
   Pills Tubal Ligation Condoms Withdrawal Depo Provera IUD
   Foam Vasectomy Diaphragm Implants Other
5. Are you having any problems with your method of Birth Control? .... ____YES .... ____NO
6. Have you ever had any vaginal, cervical, and/or tubal infection? .... ____YES .... ____NO
   If yes, please check below:
   ____Yeast ____Gardnerella ____ Condyloma ____ Bacterial Vaginitis
   ____Herpes ____Trichomonas ____ Chlamydia ____Gonorrhea ____Warts ____ PID ____ Other
7. **Date of last pap smear:** ____________________
8. Have you ever had an abnormal pap smear? .... ____YES .... ____NO
   If yes, how was it treated? Please check below.
   _____ Repeated Pap Smear _____ Colposcopy _____ Laser Surgery _____ Cone Biopsy
   _____ Cryosurgery (Freezing) _____ Hysterectomy _____ Loop Excision
9. Do you have trouble leaking urine? .... ____YES .... ____NO
10. Do you have any breast lumps, tenderness or discharge? (Please circle which) .... ____YES .... ____NO
10a. **Have you had a mammogram?** .... ____YES .... ____NO
    If yes, was it normal? .... ____YES .... ____NO
    Date of last mammogram: __________ **Where:** ____________________
11. Do you do breast self exam? .... ____YES .... ____NO
12. Do you have PMS symptoms? .... ____YES .... ____NO
    If yes, any treatment? ____________________
13. Do you have any hot flashes or menopausal symptoms? .... ____YES .... ____NO
14. Do you have any uterine anomalies? .... ____YES .... ____NO
15. Do you have a history of infertility? .... ____YES .... ____NO
16. Do you have a history of DES Exposure? .... ____YES .... ____NO

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Patient Name: ____________________
Date: __________

MENSTRUAL HISTORY

1. If you no longer have periods please state reason: ____________________
2. First day of last period: ____________________
3. How many days does your period last? ____________________
4. Are your periods regular? ____YES ____NO
5. How many days from the start of one period to the start of the next period? __________
6. Has the flow changed in any way? ________ If so, how? ____________________
7. Do you have any bleeding between periods? ____YES ____NO
8. Do you have any cramping with your periods? ____YES ____NO
   If yes, circle one: Mild Moderate Severe
9. Medicine taken for cramps: ____________________

SOCIAL HISTORY

1. Do you smoke? ____YES ____NO
2. Do you use street drugs? ____YES ____NO
3. Do you drink alcohol? ____YES ____NO
   If yes, how much per day? ____________________

PAST MEDICAL HISTORY

1. Are you or your partner of Jewish decent (for genetic screening purposes)? ____YES ____NO
2. Do you have diabetes? ____YES ____NO
3. Do you have/had hypertension? ____YES ____NO
4. Do you have heart disease? ____YES ____NO
5. Do you have a heart murmur? ____YES ____NO
6. Do you have/had kidney disease? ____YES ____NO
7. Have you ever been treated for psychiatric problems ____YES ____NO
8. Have you ever had rheumatic fever? ____YES ____NO
9. Do you have mitral valve prolapse? ____YES ____NO
10. Have you ever had a urinary tract infection? ____YES ____NO
11. Have you ever had hepatitis/liver disease? ____YES ____NO
12. Have you ever had varicosities/phlebitis? ____YES ____NO
13. Do you have any thyroid problems? ____YES ____NO
14. Have you had any major accidents? ____YES ____NO
15. Have you ever had any blood transfusions? ____YES ____NO
16. Do you have asthma/lung disease? ____YES ____NO
17. Do you have any Drug Allergies? ____YES ____NO
    If yes, please list: ____________________
18. Please list any GYN Surgery: ____________________
    ____
    ____
19. Please list any other operations/hospitalizations (year and reason): ____________________
    ____
    ____
    ____
    ____
20. Have you had any anesthesia complications? ____YES ____NO
    If yes, list: ____________________
21. Have you ever been anemic? ____YES ____NO
22. Are you on any medications? Please list with dosage: ____________________
    ____
    ____

VACCINATIONS / BOOSTERS

1. Have you ever been vaccinated for Hepatitis A? ____YES ____NO
2. Have you ever been vaccinated for Hepatitis B? ____YES ____NO
3. Have you ever had a pertussis (whooping cough) Tdap booster? ____YES ____NO
4. Have you had a recent tetanus booster? ____YES ____NO
5. Have you had a flu shot this flu season (10/1 - 4/30)? ____YES ____NO
6. If under 25, have you ever had cervical cancer vaccinations? ____YES ____NO

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Patient Name: ______________________________

Date: ______________

FAMILY HISTORY

1. Do you have a family history of breast cancer? .... ____YES .... ____NO
   If yes, who? ______________________________
2. Do you have a family history of colon cancer? .... ____YES .... ____NO
   If yes, who? ______________________________
3. Do you have a family history of ovarian cancer? .... ____YES .... ____NO
   If yes, who? ______________________________
4. Do you have a family history of osteoporosis? .... ____YES .... ____NO
   If yes, who? ______________________________
5. Do you have a family history of diabetes? .... ____YES .... ____NO
   If yes, who? ______________________________
6. Do you have a family history of hypertension? .... ____YES .... ____NO
   If yes, who? ______________________________
7. Do you have a family history of heart disease? .... ____YES .... ____NO
   If yes, who? ______________________________
8. Do you have a family history of kidney disease? .... ____YES .... ____NO
   If yes, who? ______________________________

OFFICE USE ONLY

EXAM

Physical E: BP____________ Wt. ____________ Ht. ______________________________

General ______________________________

____

HEENT ______________________________

Breast ______________________________

____

Chest ______________________________

Heart ______________________________

Abdomen ______________________________

____

Ext. ______________________________

Pelvic: Vulva: ______________________________

Vag: ______________________________

Cervix: ______________________________

Uterus: ______________________________

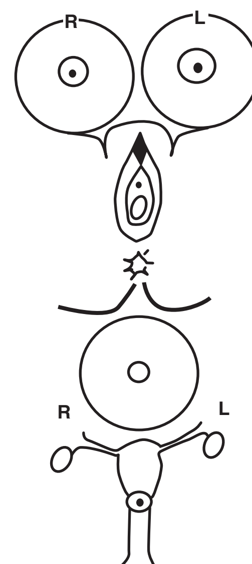
____

Adnexa: ______________________________

____

Recto Vaginal: ______________________________

____



Lab: Hbg. ____________ Urine ____________ Pap Smear Yes ___ No ___

Assessment: ______________________________

____

____

____

____

Plan: ______________________________

____

____

Mammogram Ordered: ________ Yes ________ No

Time Spent: ____________________ Signed ______________________________