

PATIENT VISIT

Name: _____ Age: _____ Today's Date: _____

Preferred Name: _____

Who is your regular doctor: Echemendia Hart Lee Long Nix Otto Parker Robbins Sugarman Zane

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



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

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 _____

