

<b>Patient History</b>	Name:	Date of Birth:
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**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 Clot in Lungs or Legs		High Blood Pressure	
Blood Transfusions		High Cholesterol	
Bowel Problems		HIV/Aids	
Broken Bones		Kidney Infection/Kidney Stones	
Cancer		Pneumonia/Lung Disease	
Cataracts		Reflux/Hiatal Hernia/Ulcer	
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**

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 specify)			

**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		
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 all that apply**

Illness	Mother	Father	Sibling	Child	Maternal GMother	Maternal GFather	Paternal GMother	Paternal GFather	Other (who)
Breast Cancer									
Colon Cancer									
Ovarian Cancer									
Alzheimer's Disease									
Birth Defects									
Blood Clots in lungs or legs									
Diabetes									
Drinking or Drug Problem									
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 Abortions
_____ # Miscarriages	_____ # Ectopic	_____ # Multiples	_____ # Living _____ #Adopted

<b>Pregnancy Details</b>	<b>#1</b>	<b>#2</b>	<b>#3</b>	<b>#4</b>	<b>#5</b>	<b>#6+</b>
Pregnancy Outcome F = Full term, P = Premature, M = Miscarriage						
Delivery Date						
Weeks at Delivery						
Length of Labor (hrs)						
Epidural/Anesthesia						
Delivery Type V = Vaginal, C = C-Section						
Did you have Pre-term Labor?						
Delivery Location?						
Who delivered your baby?						
Baby weight?						
Baby Sex?						
Baby Name?						

<b>Complications of Pregnancy</b>	<b>Please check all that apply</b>					
Gestational Diabetes						
Macrosomia						
Multiple Gestation						
Post Dates						
Postpartum hemorrhage						
Pre-eclampsia						
Preterm Delivery						
Other Complication						

## New Patient Office Visit

Name:		Date of Birth:	
<b>Current Medications (include hormones, herbs, vitamins, nonprescription medicine)</b>			
Name and Dosage		Name and Dosage	
1.		4.	
2.		5.	
3.		6.	
<b>Allergies (please include all drug allergies)</b>			
1.		4.	
2.		5.	
3.		6.	
<b>What is your problem today:</b>			
Describe your problem. Location / Quality / Severity / Duration / Timing / Context / Modifying Factors / Assoc. Signs & Symptoms:			
<b>Since Your Last Visit:</b>			
	<b>Yes</b>	<b>No</b>	<b>Please Describe:</b>
Have you been diagnosed with a new medical problem since your last visit?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any surgeries since your last visit?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you been diagnosed with a new allergy?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any new family history (parents, siblings, children)?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Annual Care</b>			<b>YES</b>
			<b>NO</b>
Do you take Vitamin D – 1000-2000 units a day?			<input type="checkbox"/>
Caffeine use - how many drinks per day?			<input type="checkbox"/>
Have you seen your PCP in the last year?			<input type="checkbox"/>
Did they do lab work?			<input type="checkbox"/>
What year was your last Mammogram?	Bone Density?	Colonoscopy?	
<b>Menstrual History</b>			<b>YES</b>
			<b>NO</b>
Are you menopausal?			<input type="checkbox"/>
Have you had a hysterectomy?			<input type="checkbox"/>
Are you currently pregnant?			<input type="checkbox"/>
What was your age at your first menstrual period?			
Date of your last menstrual period:			
Are your periods regular (28-30 days)?			<input type="checkbox"/>
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?			<input type="checkbox"/>
If Yes, how bad is that pain? Minimal Mild Moderate Severe			
Do you have a problem with heavy bleeding?			<input type="checkbox"/>
Do you bleed after intercourse?			<input type="checkbox"/>
Do you have bleeding between your periods?			<input type="checkbox"/>
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? Male Female			
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			
<b>What type of contraception do you currently use?</b> None Essure Tubal Ligation Hysterectomy Same Sex Partner Abstinence Rhythm Method Male Withdrawal Condoms Spermicides Diaphragm Nexplanon Norplant Pills Patch Ring Shot IUD-Paragard IUD-Mirena Implanon IUD-Liletta			
<b>What type of contraception have you previously used?</b> None Abstinence Rhythm Method Same Sex Partner Male Withdrawal Condoms Spermicides Diaphragm Norplant Pills Patch Ring Shot IUD-Paragard IUD-Mirena Implanon Nexplanon IUD-Liletta IUD-Skyla			