

Capital Area OB - GYN

NAME: _____ DATE: ___/___/___ BIRTHDATE: ___/___/___

REFERRED BY: _____ AGE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

REASON FOR VISIT: ROUTINE PHYSICAL PROBLEM DESCRIBE PROBLEM: _____

CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

MAJOR ILLNESSES	YES	NO	MAJOR ILLNESSES	YES	NO
Acne / Eczema			High Cholesterol		
Anemia			Incontinence		
Anxiety			Irritable Bowel Syndrome		
Arthritis / Joint pain			Kidney Infections		
Asthma			Kidney Stones		
Blood transfusions			Lupus		
Bowel Trouble			Mood Disorders		
Breast Cancer			Osteoporosis		
Cancer			Pneumonia		
Chronic Lung Disease			Polycystic Ovarian Syndrome		
Crohn's Disease			Rheumatic Fever		
Depression			Seizures		
Diabetes			Sexually Transmitted Diseases		
Fracture			Stroke		
Gastroesophageal Reflux Disease			Tuberculosis - TB		
Glaucoma			Thyroid Disease		
Headaches			Ulcers		
Heart Murmur			Ulcerative Colitis		
Heart Trouble			OTHER:		
Hepatitis / Jaundice					
High Blood Pressure					

WHEN WAS YOUR LAST TEST OR IMMUNIZATION?

	DATE		DATE
Bone Density		Tetanus Vaccine	
Colonoscopy / Sigmoidoscopy		Mammogram	
Flu Shot		Last PAP Smear	
Gardasil Vaccine		TB Skin Test	
Pneumonia Vaccine		OTHER:	
Shingles Vaccine			

PLEASE LIST ANY PAST INJURIES OR ILLNESSES:

TYPE	DATE	TYPE	DATE

NAME: _____

BIRTHDATE: ___/___/___

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

SURGERY / REASON	DATE	SURGERY / REASON	DATE

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

DRUG NAME	DOSAGE	PHYSICIAN	DRUG NAME	DOSAGE	PHYSICIAN

ALLERGIES TO MEDICATIONS / SUBSTANCES (LATEX GLOVES, ETC.?)/TYPE OF REACTION

List:

CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:

MAJOR ILLNESSES	YES	NO	What Blood relative? Age at diagnosis?
Anemia			
Arthritis / Joint pain			
Asthma			
Blood Clots			
Bowel Trouble / Ulcers			
Breast Cancer			
Ovarian Cancer			
Colon Cancer			
Uterine Cancer			
Cancer			
Chronic Lung Disease			
Depression / Anxiety / Mood Disorders			
Diabetes			
Glaucoma			
Heart Trouble / Murmur			
Hepatitis / Jaundice			
High Blood Pressure			
High Cholesterol			
Kidney Infections / Stones			
Osteoporosis			
Stroke			
Thyroid Disease			
Tuberculosis - TB			
OTHER:			

NAME: _____ BIRTHDATE: ___/___/___

YOUR GYN HISTORY

Have you ever had an abnormal pap smear? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what was the abnormality?	
If yes, were you treated?	
Do you use birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sexually active	
<input type="checkbox"/> Condoms	<input type="checkbox"/> Nuvaring
<input type="checkbox"/> Depo Provera	<input type="checkbox"/> Birth Control Patch
<input type="checkbox"/> Diaphragm	<input type="checkbox"/> None
<input type="checkbox"/> IUD- Kind	<input type="checkbox"/> Natural Family Plan/Rhythm
- Date Inserted:	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Birth Control Pill	<input type="checkbox"/> Vasectomy
- Name:	<input type="checkbox"/> Withdrawal
<input type="checkbox"/> Contraceptive Foam/Jelly	<input type="checkbox"/> Other:
What age did you have your first period: _____	
How many days are there from start of period to start of next period: _____ days	
How long does your period last? _____ days Flow: <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy	
Number of Tampons per day: _____ Number of Pads per day: _____	
Date of Last Period: _____	
Do you have clots? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have bleeding between menses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have cramps? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have pain? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you gone thru Menopause: <input type="checkbox"/> Yes <input type="checkbox"/> No At what age: _____	
Are you on Hormone Replacement Therapy (hormones)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

YOUR OB HISTORY

	NUMBER		NUMBER
Total # of pregnancies		Full term births	
Premature		Abortions	
Miscarriages		Living children	

On the chart below, please fill in answers for each pregnancy including abortions or miscarriages.

If you have had a tubal ligation, previous hysterectomy, or if you are postmenopausal you may skip to the next section.

No.	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight/Sex	Del Type Vag/CSection	Anes	Early Labor?	Wt Gain	Comments / Complications	Location
1				M						
				F						
2				M						
				F						
3				M						
				F						
4				M						
				F						
5				M						
				F						
6				M						
				F						

Have you had diabetes in pregnancy? Yes No

SOCIAL HISTORY

Do you use Seat Belt? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you do a Self Breast Exam? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you Take Calcium <input type="checkbox"/> Yes <input type="checkbox"/> No Name and Dosage: _____	
Do you Exercise: <input type="checkbox"/> None <input type="checkbox"/> Less than 3 times per week <input type="checkbox"/> More than 3 times per week	
Have you ever had sexual intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you sexually active currently? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have sex with? <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both	
First Intercourse at Age: _____ Frequency: _____ Week	
New sexual partner <input type="checkbox"/> Yes <input type="checkbox"/> No Lifetime sexual partners <input type="checkbox"/> Less than 5 <input type="checkbox"/> More than 5	
Are you married/single/divorced/widowed? _____ Occupation _____	
Smoking <input type="checkbox"/> Yes <input type="checkbox"/> Quit <input type="checkbox"/> Never Packs per day: _____ Number of Years: _____	
Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks per day: _____ Drink per week: _____	
Drug User <input type="checkbox"/> Yes <input type="checkbox"/> Quit <input type="checkbox"/> Never Kind: _____ Frequency: _____	
History of abuse <input type="checkbox"/> Yes <input type="checkbox"/> No Do you feel safe now? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Sexual	
List all "Natural" or Herbal remedies, over the counter drugs, vitamins or minerals you are taking.	List: _____

