

Women's Health Alliance, PA pka
Centre Ob/Gyn
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(919) 788-4444
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Chart#: _____

Name: _____ Date: ____/____/____

Who Referred You? _____ Age: _____ y.o.

Why are you here today?

GYN History:

- 1. What was the first day of your last menstrual period? ____/____/____
- 2. What method of birth control are you using? _____
- 3. How many days do you flow? _____
- 4. How often are your periods? _____
- 5. Do you have painful periods? _____ Yes No
- 6. Do you have bleeding between periods? _____ Yes No
- 7. Are you planning pregnancy in the future? _____ Yes No
- 8. Do you have a history of abnormal Pap smears? _____ Yes No

Medical History:

Please Circle One

- 1. List any medications or herbals taken? _____ Yes No
- 2. Are you allergic to any medications or herbals? _____ Yes No
- 3. Are you under the care of any other physicians? _____ Yes No
If so, which physician and for what reason? _____
- 4. Do you do monthly breast exams? _____ Yes No
- 5. Do you check your skin regularly for abnormalities? _____ Yes No
- 6. Have you had a tetanus shot within the last 10 years? If yes, when: _____ Yes No
- 7. Have you had your cholesterol checked within the last 5 years? If yes, when: _____ results: _____ Yes No
- 8. When was your last mammogram? _____ results: _____

Family History:

Please Circle One

- Has your family medical history changed in the last year? _____ Yes No
- If so, please specify: _____

Social History:

Please Circle One

- 1. Do you smoke? Amount: _____ Yes No
- 2. Do you drink alcohol? Amount: _____ Yes No
- 3. Do you use any illegal drugs? _____ Yes No
- 4. Do you wear seat belts? _____ Yes No
- 5. Do you think you may have a current sexually transmitted disease? _____ Yes No
- 6. Are you or any other member of your family in an abusive situation? _____ Yes No

Review of Systems * Circle if you CURRENTLY have any of the following Symptoms or Complaints *****

- 1. **General Symptoms:** fevers-fatigue-marked weight change-hot flashes-eating disorder
- 2. **Skin:** change in any moles-new moles-new skin lesions- ashes-skin ulcers
- 3. **Eyes:** change in vision-wear glasses or contacts
- 4. **Breasts:** discharge-pain-lumps
- 5. **Respiratory Systems:** cough-wheezing-coughing up blood-shortness of breathe
- 6. **Cardiovascular System:** irregular heartbeats-chest pain-shortness of breathe with exertion trouble breathing when lying down at night-palpitations-swelling
- 7. **Gastrointestinal Tract:** nausea-vomiting-heartburn-abdominal pain-gas-diarrhea-constipation
- 8. **Urinary Tract:** blood in urine-pain with urination-losing urine when coughing or sneezing urinating more frequently-urinary urgency-incomplete bladder emptying
- 9. **Reproductive System:** abnormal bleeding-pain with intercourse-sexual dysfunction
- 10. **Musculoskeletal System:** joint pain-weakness
- 11. **Lymph Nodes:** enlargement
- 12. **Nervous System:** numbness-fainting spells-seizures-trouble walking-new onset of headaches
- 13. **Hematologic:** easy bleeding or bruising
- 14. **ENT/Mouth:** ulcers-ringing in ears-frequent headaches-sinus pain
- 15. **Psychologic:** depression-crying

FOR OFFICE USE ONLY:
*ROS-Negative

*All Other Systems Negative

Patient's Signature

_____/_____/_____
Date