Name: _____ Age: _____

Date of Birth: _____ Today's Date: _____

Primary Care Provider: _____

Reason for visit today: _____

Rutherford OB-GYN Associates, P.A.
"Caring for Women... Caring for Life"

Problems

Any current diagnosed problems? ❑ **Check if no known problems**

_____	Approximate Onset	_____	❑ Acute	❑ Chronic
_____	Approximate Onset	_____	❑ Acute	❑ Chronic
_____	Approximate Onset	_____	❑ Acute	❑ Chronic

Surgical History

Have you had any Surgeries? ❑ **Check if no surgeries**

_____	Approximate Date	_____
_____	Approximate Date	_____
_____	Approximate Date	_____

Current Medication History ❑ Check if no medications

Do you currently take any medications? Include over the counter drugs. Please include dosing information.

_____ _____

_____ _____

_____ _____

_____ _____

Vaccine History

Have you had any of these vaccines?

Tetanus or Tdap?	❑ Yes	❑ No	Date _____	Shingles Vaccine?	❑ Yes	❑ No	Date _____
HPV (Gardisil)?	❑ Yes	❑ No	Date _____	Pneumococcal?	❑ Yes	❑ No	Date _____
Yearly Flu shot?	❑ Yes	❑ No	Date _____	Other? _____			Date _____

Allergies / Adverse Reactions

Do you have any allergies to drugs or foods? ❑ **Check if no known drug allergies (NKDA)**

_____	Symptom	_____	Severity	_____
_____	Symptom	_____	Severity	_____
_____	Symptom	_____	Severity	_____

Past Medical History ❑ Check if no to all

Please check if **"yes"** for yourself only.

	Comments		Comments
❑ Cancer-BRCA Tested	_____	❑ Cardiac-Heart Arrhythmia	_____
❑ Cancer-Breast	_____	❑ Cardiac-Heart Attack	_____
❑ Cancer-Cervical	_____	❑ Cardiac-Heart Disease	_____
❑ Cancer-Colon	_____	❑ Cardiac-Heart Murmur	_____
❑ Cancer-Endometrial	_____	❑ Cardiac-High Blood Pressure	_____
❑ Cancer-Lung	_____	❑ Cardiac-High Cholesterol	_____
❑ Cancer-Other	_____	❑ Cardiac-Mitral Valve Prolapse	_____
❑ Cancer-Ovary	_____	❑ Cardiac-Other	_____
❑ Cancer-Skin	_____	❑ Dermatology-Acne (severe)	_____
❑ Cancer-Vaginal	_____	❑ Dermatology-Eczema/Psoriasis	_____
❑ Cancer-Vulvar	_____	❑ Dermatology-Other	_____
❑ Cardiac-Aneurysm	_____	❑ ENT-Hearing Loss	_____
❑ Cardiac-Atrial fib/atrial flutter	_____	❑ ENT-Other	_____

Please continue with medical history on the back of this page.

Past Medical History - Continued

❑ **Check if no to all**

Please check if **"yes"** for yourself only.

- ❑ Endocrinology-Diabetes
- ❑ Endocrinology-History of Gestational Diabetes
- ❑ Endocrinology-Elevated Prolactin
- ❑ Endocrinology-Osteopenia
- ❑ Endocrinology-Osteoporosis
- ❑ Endocrinology-Other
- ❑ Endocrinology-Thyroid Problems
- ❑ Eyes-Vision Loss/Macular Degeneration
- ❑ GI-Colon Polyps
- ❑ GI-Crohn's/Ulcerative Colitis
- ❑ GI-Gallbladder Disease
- ❑ GI-Hemorrhoids
- ❑ GI-Irritable Bowel Syndrome
- ❑ GI-Liver Disease/Hepatitis
- ❑ GI-Other
- ❑ GI-Reflux/Stomach Ulcers
- ❑ GI-Vitamin Deficiency
- ❑ Hematology-Anemia
- ❑ Hematology-Bleeding Disorder
- ❑ Hematology-Clotting Disorder/Factor V Leiden
- ❑ Hematology-Blood Transfusion
- ❑ Hematology-DVT/Pulmonary Embolism
- ❑ Hematology-Other
- ❑ ID-Chicken Pox/Shingles
- ❑ ID-HIV
- ❑ ID-Other
- ❑ ID-Rheumatic Fever
- ❑ ID-Tuberculosis/Positive PPD
- ❑ ID-Usual childhood diseases-Chicken Pox
- ❑ Neurology-Headaches/Migraines
- ❑ Neurology-Memory Loss/Dementia
- ❑ Neurology-Neuropathy
- ❑ Neurology-Other
- ❑ Neurology-Seizures/Epilepsy
- ❑ Neurology-Stroke/TIA
- ❑ Ortho-Chronic Back Pain
- ❑ Ortho-Degenerative Joint Disease
- ❑ Ortho-Fractures
- ❑ Ortho-Other
- ❑ Psych-ADD
- ❑ Psych-Anxiety Disorder
- ❑ Psych-Bipolar Disease
- ❑ Psych-Depression
- ❑ Psych-Eating Disorder
- ❑ Psych-Mental Disorder
- ❑ Psych-Other
- ❑ Psych-PMS/PMDD
- ❑ Pulmonary-Asthma
- ❑ Pulmonary-COPD/Emphysema
- ❑ Pulmonary-Lung Disease
- ❑ Pulmonary-Other
- ❑ Pulmonary-Seasonal /Allergic Rhinitis
- ❑ Pulmonary-Sleep Apnea
- ❑ Rheumatology-Arthritis
- ❑ Rheumatology-Autoimmune Disease
- ❑ Rheumatology-Fibromyalgia/Chronic Pain
- ❑ Rheumatology-Other
- ❑ Rheumatology-Restless Leg Syndrome
- ❑ Urology-Frequent Urinary Tract Infections
- ❑ Urology-Hematuria (Blood in Urine)
- ❑ Urology-Interstitial Cystitis
- ❑ Urology-Kidney Disease
- ❑ Urology-Kidney Infection
- ❑ Urology-Kidney or Bladder Problems
- ❑ Urology-Other
- ❑ Urology-Urinary Incontinence
- ❑ Weight Management

Additional explanations, if necessary, of any "Yes" checked items:

Social History

Smoking Status: ❑ Never ❑ Former Quit? _____ ❑ Current How long / how much? _____

Exercise Level: ❑ None ❑ Occasional ❑ Moderate ❑ Heavy

Diet: ❑ Regular ❑ Vegetarian ❑ Gluten Free ❑ Carbohydrate ❑ Cardiac ❑ Diabetic ❑ Special _____

Alcohol Intake: ❑ None ❑ Occasional ❑ Moderate ❑ Heavy How much? _____

Caffeine Intake: ❑ None ❑ Occasional ❑ Moderate ❑ Heavy How much? _____

Do you use illicit drugs? ❑ Yes ❑ No If yes, what are you using? _____

Ethnic background: ❑ Caucasian ❑ African American ❑ Latin ❑ Native American ❑ Other _____

Education level: _____ Occupation: _____

Currently Employed? ❑ Yes ❑ No Occupational health risks: _____

Please continue with social history on the next page.

Social History - Continued

Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Widowed ❑ Domestic Partner

History of Domestic Violence? ❑ Yes ❑ No General Stress Level: ❑ Low ❑ Medium ❑ High

Family History (mother, father, brother, sister, son, daughter) ❑ **Check if unknown** ❑ **Check if Non-contributory**

Relation	Problem	Age at onset	Died of Age	Comments:

GYN History

Date of last mammogram _____ History of abnormal PAP? ❑ Yes ❑ No _____

Date of last colonoscopy _____ Had the HPV vaccine? ❑ Yes ❑ No _____

Date of last bone scan _____ Have you had an HPV test? ❑ Yes ❑ No _____

Date of last PAP smear _____ History of cervical dysplasia? ❑ Yes ❑ No _____

Age when started mensus _____ Current birth control method _____

Date of last menstral period _____ Are you menopausal? ❑ Yes ❑ No Age at Menopause _____

History of Endometriosis ❑ Yes ❑ No Post menopausal hormones? ❑ Yes ❑ No If yes: _____

History of Fibroids ❑ Yes ❑ No History of Ovarian Problems ❑ Yes ❑ No

History of Infertility ❑ Yes ❑ No History of PCOS ❑ Yes ❑ No

Comments: _____

Sexual History

Have you ever been sexually active? ❑ Yes ❑ No Are you currently sexually active? ❑ Yes ❑ No

Age at first intercourse _____ Have you had any STD's? ❑ Yes ❑ No If yes, what? _____

Number of partners _____ Other comments: _____

Pharmacies What pharmacies do you prefer to have your prescriptions called/faxed to?

Preferred pharmacy: Name: _____ Phone: _____

Mail order pharmacy: Name: _____ Phone: _____

Past Pregnancies

Date - #Wks - Hrs Labor - Birth Wt. - Sex - Type of Delivery - Anesthesia - Place of Del. - Preterm Labor? - Complications?

Obstetric History

Total	Full term	Preterm	Abortions	Miscarriages	Ectopics	Multiples	Living	Deceased