

WOMEN'S HEALTHCARE GROUP OF PA

TODAY'S DATE: _____

PATIENT NAME: _____

AGE: _____

BIRTHDATE: _____

PREFERRED PHARMACY NAME _____ ZIP CODE _____

REASON FOR VISIT: ANNUAL GYN VISIT FIRST OBSTETRIC VISIT

GYN PROBLEM VISIT- DESCRIBE PROBLEM BELOW:

| Past Medical History (Answer all boxes that apply): | |
|--|--|
| Previous History | Last Colonoscopy: Date: _____ Result: Normal Abnormal |
| | Last Dexa Scan: Date: _____ Result: Normal Abnormal |
| | Last Mammogram: Date: _____ Result: Normal Abnormal |
| | Last Pap Smear: Date: _____ Result: Normal Abnormal |
| | Gardasil Injections: <input type="checkbox"/> No <input type="checkbox"/> Yes- How many injections _____ |

| Major Illnesses (Answer all boxes that apply): | | | | | |
|---|-----|----|---------------------------------|-----|----|
| | YES | NO | | YES | NO |
| Abnormal Pap Smear | | | Genital Warts | | |
| Anemia | | | Hepatitis: A B C | | |
| Anxiety | | | High Blood Pressure | | |
| Arthritis/ Joint Pain | | | High Cholesterol | | |
| Asthma | | | IBS (Irritable Bowel Syndrome) | | |
| Blood Transfusions | | | Interstitial Cystitis | | |
| Blood Clots/ Deep Vein | | | Migraines: with or without Aura | | |
| Breast Cancer | | | Osteoporosis | | |
| Cancer: Type: | | | Seizures | | |
| | | | Sexually Transmitted Diseases | | |
| Chronic Lung Disease | | | Stroke | | |
| Depression | | | Tuberculosis- TB | | |
| Diabetes: Type: _____ | | | Thyroid Disorder- Hyperthyroid | | |
| Fractures | | | Thyroid Disorder- Hypothyroid | | |
| Fibroids | | | Ulcers | | |
| <input type="checkbox"/> No Past Medical History | | | | | |

List Other Major Diseases: _____

| Past Surgical History | |
|---|-----------|
| Year | Operation |
| | |
| | |
| | |
| | |
| <input type="checkbox"/> No Past Surgical History | |

| Current Medications: Prescription and non-prescription medicine, vitamins, home remedies, birth control pills, herbs: | | | |
|---|-------------|-----------|-----------------------|
| Medication | Dosage (mg) | Frequency | Prescribing Physician |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Drug Allergies: | Reactions |
|--|-----------|
| | |
| | |
| | |
| | |
| LATEX Allergy: <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| IODINE Allergy: <input type="checkbox"/> No <input type="checkbox"/> Yes | |

| Family History | | | | | | | | | | | |
|---|------|--------|--------|---------|--------|------------------------|------------------------|------------------------|------------------------|------|-------|
| Please indicate below significant medical problems of family members. Indicate which family members by checking the appropriate column. | | | | | | | | | | | |
| | None | Mother | Father | Brother | Sister | Grandmother (Maternal) | Grandmother (Paternal) | Grandfather (Maternal) | Grandfather (Paternal) | Aunt | Uncle |
| Blood Clots/ Deep Vein | | | | | | | | | | | |
| Breast Cancer | | | | | | | | | | | |
| Cervical Cancer | | | | | | | | | | | |
| Colon Cancer | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | |
| Heart Disease | | | | | | | | | | | |
| Hypertension | | | | | | | | | | | |
| Ovarian Cancer | | | | | | | | | | | |
| Stroke | | | | | | | | | | | |
| Uterine Cancer | | | | | | | | | | | |

| Genetic Screening: Includes patient, baby's father, or anyone in either family | | | | | |
|--|-----|----|--|-----|----|
| | YES | NO | | YES | NO |
| Tay-Sachs (Jewish, Cajun, French Canadian) | | | Sickle Cell Disease or Trait (African) | | |
| Neural Tube Defect (Meningomyelocele, Spine Bifida, or Anencephaly) | | | Maternal Metabolic Disorder (Insulin- Dependent, Diabetes, PKU) | | |
| Other inherited Genetic or Chromosomal Disorder | | | Mental Retardation/ Autism * If yes, was person tested for Fragile X | | |
| Thalassemia (Italian, Greek, Mediterranean, or Asian Background) | | | Medications/ Street Drugs/ Alcohol since last menstrual period * If yes, agent (s) | | |
| Hemophilia | | | Muscular Dystrophy | | |
| Cystic Fibrosis | | | Huntington Chorea | | |
| Down Syndrome | | | Congenital Heart Defect | | |
| Patient or baby's father had a child with birth defects not listed above | | | Recurrent pregnancy loss or a stillbirth | | |

| Review of Systems: (Check all that are applicable to your current reason for visit) | |
|--|--|
| Constitutional | Chills _____ Excessive Urination _____ Fever _____ Weight Gain _____ Excessive Thirst _____ Fatigue _____ Night Sweats _____ Weight Loss _____ |
| Eyes | Recent changes in vision _____ |
| HENT (Head, Ears, Nose, & Throat) | Hay fever or allergies _____ Problems with teeth or gums _____ Sinus pain/ congestion _____ |
| Breasts | Changes in Skin _____ Discharge _____ Lumps _____ Pain _____ |
| Cardiovascular | Chest Pain _____ Palpitations _____ |
| Respiratory | Cough _____ Shortness of breath _____ Wheezing _____ |
| Gastrointestinal | Abdominal Pain _____ Blood in stools _____ Diarrhea _____ Nausea _____ Bloating _____ Constipation _____ Vomiting _____ |
| Genitourinary/ Gynecological | Frequency of Urination _____ Incontinence _____ Sexual Dysfunction _____ Blood in Urine _____ Pain with Urination _____ Urgency of Urine _____ Vaginal Discharge _____ Vaginal Odor _____ Vaginal Itching _____ Pain with Intercourse _____ Decreased Sex Drive _____ |
| Integument | Changes to existing skin lesions or moles _____ Rash _____ |
| Neurological | Dizzy/ Lightheaded _____ Headaches _____ |
| Psychiatric | Anxiety _____ Depression _____ Difficulty Sleeping _____ |
| Heme-Lymphatics | Bleeding Disorder _____ Unexplained Lumps _____ |
| Others not listed above | |

Reproductive History

| | | |
|------------|--|-------------------|
| Gynecology | <p>If you are menopausal, skip to the next section</p> <p>Date of Last Menstrual Period: _____</p> <p>What age did you have your first period: _____</p> <p>How many days are there from start of period to start of next period: _____ days</p> <p>How many days long does your period last: _____ days</p> <p>Menstrual Flow: Light _____ Moderate _____ Heavy _____</p> <p>On your heaviest days, how often do you change your tampon or pad: _____</p> <p>What method of birth control do you use: _____</p> <p>Do you have breakthrough bleeding between periods: No _____ Yes _____</p> <p>Do you see large clots: No _____ Yes _____</p> <p>Are you interested in having more children: No _____ Yes _____</p> | |
| Menopause | <p>At what age did you become menopausal: _____</p> <p>If you have hot flashes or night sweats are they: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe</p> <p>Are you on hormone replacement therapy: No _____ Yes _____</p> <p>Have you had any vaginal bleeding this year: No _____ Yes _____</p> | |
| Obstetrics | Total number of pregnancies | Number (s) |
| | Full Term Births | |
| | Premature Births | |
| | Twin/ Triplet Births | |
| | Miscarriages | |
| | Abortions Induced | |
| | Ectopic Pregnancy | |
| | Living Children | |

| No. | Birth Date | # of weeks at Delivery | Birth Weight | Sex M/F | Delivery Type Vag/ CSection | Complications | Location of Delivery |
|-----|------------|------------------------|--------------|---------|-----------------------------|---------------|----------------------|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |

Social History

| | |
|-----------------|--|
| Occupation | What is your current occupation: _____ |
| Marital Status | Married _____ Divorced _____ Domestic Partner _____ Single _____ Widowed _____ |
| Sexual Activity | Are you sexually active: Yes _____ No _____ Not Currently _____ Never _____ Current sexual partner (s) is/are: Male _____ Female _____ Have you had more then (4) sexual partners in your lifetime: No _____ Yes _____ Have you ever had any sexually transmitted diseases (STDs): No _____ Yes _____ * If yes, please specify _____ Interested in being screened for sexually transmitted diseases: No _____ Yes _____ |
| Alcohol Use | No _____ Yes _____ Social Drinker _____ Drinks per week: _____ Is alcohol use a concern for you or others: No _____ Yes _____ |
| Drug Use | Do you use recreational drugs: No _____ Yes _____ Have you ever used needles: No _____ Yes _____ |
| Tobacco Use | Cigarettes: No _____ Yes _____ Social Smoker _____ Quit _____ Date: _____ Current Smoker: Packs per day _____ Number of years: _____ |
| Safety | Is violence at home a concern for you: No _____ Yes _____ Have you ever been abused: No _____ Yes _____ |
| Lifestyle | Do you do self breast exams: No _____ Yes _____ Do you drink milk or eat dairy products daily: No _____ Yes _____ Do you take calcium tablets: No _____ Yes _____ Do you exercise: No _____ Yes _____ * If yes, number of times per week _____ Are you satisfied with your weight: No _____ Yes _____ |

Patient Signature: _____ **Date:** _____