

Name \_\_\_\_\_  
Age: \_\_\_\_\_  
Primary Care Physician (not OB/Gyn) \_\_\_\_\_

Chart # \_\_\_\_\_

**GYNECOLOGIC HISTORY**

Last menstrual period \_\_\_\_\_  
Method of birth control (circle one)  
not sexually active  
condoms  
DepoProvera  
IUD  
oral contraceptive pills  
tubal ligation/vasectomy  
early withdrawal  
contraceptive patch  
contraceptive ring  
Last pap smear: \_\_\_\_\_ normal/abnormal  
Last mammogram \_\_\_\_\_ normal/abnormal  
Last sigmoid/colonoscopy \_\_\_\_\_  
Last bone density test \_\_\_\_\_

**MEDICAL HISTORY**

Have you ever had.....(circle)  
Abnormal pap smears, infertility, fibroids  
Endometriosis, painful periods, or  
Sexually transmitted infections \_\_\_\_\_  
Have you ever had.....(circle)  
Blood transfusion (not own blood), heart disease  
High blood pressure, high cholesterol, strokes, diabetes  
Blood clots in the legs, seizures, migraine headaches,  
Asthma. Kidney, liver, thyroid, or intestinal disease,  
eating disorder, reflux, ulcer, irritable bowel syndrome,  
arthritis, lupus, kidney stones, bladder or kidney infection

List all surgeries (gynecologic, general, & dental)  
\_\_\_\_\_  
\_\_\_\_\_

List pregnancies – include miscarriages, c-section, vaginal deliveries & problems  
\_\_\_\_\_  
\_\_\_\_\_

List all current medications (include over the counter medications, vitamins, & herbs)  
\_\_\_\_\_  
\_\_\_\_\_

List drug allergies \_\_\_\_\_  
\_\_\_\_\_

What is the nature of today's visit? (Please check one): \_\_\_\_\_ Annual Wellness Exam \_\_\_\_\_ Problem Visit

Due to insurance guidelines, we will not be able to treat any problems at the time of your annual exam. If you are experiencing problems and are here for your annual exam, you will be asked to schedule another appointment for either the annual exam or the problem, as only one will be addressed today.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**SOCIAL HISTORY**

Occupation \_\_\_\_\_  
Cigarettes per day \_\_\_\_\_  
Alcoholic drinks per week \_\_\_\_\_  
Exercise type \_\_\_\_\_  
frequency per week \_\_\_\_\_  
Marital status: S M Sep Div W

**FAMILY HISTORY:** Include parents, siblings, grandparents (maternal or paternal)

Cancer: Breast \_\_\_\_\_  
Ovarian \_\_\_\_\_  
Colon \_\_\_\_\_  
Uterine \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Thyroid disease \_\_\_\_\_  
High blood pressure \_\_\_\_\_  
Heart Disease \_\_\_\_\_  
Osteoporosis \_\_\_\_\_

**CURRENT MEDICAL CONCERNS**

Large weight change, fever, chills, hearing loss, sinus congestion, chest pain, difficulty breathing, cough, wheezing, bloody sputum, nausea, vomiting, diarrhea, constipation, bloody stools. Pain, blood, or increased frequency with urination, leakage of urine, vaginal bleeding, vaginal discharge, sexual dysfunction, painful intercourse, low sex drive, skin rashes, breast pain or discharge, breast mass, seizures, fainting episodes, mood changes, depression, heat or cold intolerance, excessive thirst or urination, hot flashes, abnormal bruising, bleeding, or anemia

Date: \_\_\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Wt: \_\_\_\_\_ BP: \_\_\_\_\_ P: \_\_\_\_\_ T: \_\_\_\_\_ R: \_\_\_\_\_

ROS	Systemic	ENT	Eyes	Lymph	Resp	CV	GI	GU	Skin	MS	Endo	Neuro	Psych	Allergy
+														
-														

OB/GYN HX: Age \_\_\_ Gravida \_\_\_ Para \_\_\_ Term \_\_\_ Pre \_\_\_ Living \_\_\_ Abortion \_\_\_ LMP \_\_\_

Date of last mammogram: \_\_\_\_\_ Date of Last Pap: \_\_\_\_\_ Contraception: \_\_\_\_\_