GynOb associates

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NAME _____ DOB _____ SS# _____

ADDRESS _____ INS. CO. _____

CITY _____ STATE _____ ZIP _____ SUBSCRIBER # _____

HOME TEL _____ WORK TEL _____ EMERGENCY CONTACT _____

OCCUPATION _____ EMPLOYER _____ EMERGENCY TEL _____

1ST DAY LMP _____ AGE 1ST PERIOD _____ DURATION _____ FREQ _____

HOW MANY PREGNANCIES HAVE YOU HAD? _____ LIVE BIRTHS? _____ MISCARRIAGES OR ABORTIONS _____ # LIVING CHILDREN _____

SMOKE _____ HOW MUCH _____ DRINK ALCOHOL _____ HOW MUCH _____

DO YOU: CAFFEINE _____ HOW MUCH _____ MARIJUANA _____ HEROIN _____ COCAINE _____

WHAT DO YOU USE FOR BIRTH CONTROL? _____

ARE YOU HAPPY WITH THIS METHOD? _____

ARE YOU ALLERGIC TO ANY:

MEDICINES _____ DYES _____ FOODS _____

_____ _____ _____

_____ _____ _____

OTHER SUBSTANCES _____

E.G., TAPE, IODINE, ENVIRONTMENTAL

HEIGHT _____ WEIGHT _____ RECENT WEIGHT LOSS _____ GAIN _____

PLEASE LIST ALL MEDICINES, PRESCRIPTION AND OVER THE COUNTER, YOU CURRENTLY TAKE (IF YOU HAVE BROUGHT MEDICINE WITH YOU, NURSE WILL GLADLY LIST FOR YOU)

_____

_____

_____

_____

PLEASE LIST ALL SURGERIES YOU HAVE HAD WITH DATES IF YOU CAN RECALL

_____

_____

_____

_____

DATE LAST PAP SMEAR _____ MAMMOGRAM _____

DO YOU HAVE ANY HISTORY OF:

CANCER		WHERE?			
HEADACHES		SEIZURES		STROKES	
DIZZYNESS		FAINTING SPELLS		PROBLEMS WITH BALANCE OR COORDINATION	
ANXIETY		DEPRESSION			
GLAUCOMA		CATARACTS		EYE SURGERY	
DO YOU WEAR GLASSES?		HEARING AID		NEED OTHER AIDS (SPLINTS, BRACES, CANES)	
CHRONIC EAR INFECTIONS		THYROID DISEASE			
ASTMA		BRONCHITIS		PNEUMONIA	
TB		EMPHYSEMA		OTHER LUNG DISEASE	
CHEST PAIN		ANGINA		HEART ATTACK	
HEART FAILURE		HIGH BLOOD PRESSURE			
HEART ARRHYTHMIA		HEART MURMUR			
MITRAL VALVE PROLAPSE		HEART CATH OR SURG			
ULCERS		INDIGESTION		GALL BLADDER DISEASE	
COLON POLYPS		DIVERTICULOSIS		CONSTIPATION	
DIARRHEA		HEMORRHOIDS		PANCREATITIS	
DIABETES		HEPATITIS		JAUNDICE	
FRACTURES		JOINT REPLACEMENTS			
ARTHRITIS		OTHER BONE PROBLEMS			
KIDNEY INFECTIONS		STONES		BLADDER INFECTIONS	
INCONTINENCE (LOSING URINE)		WITH SNEEZING		COUGHING	EXERCISE
VAGINAL DISCHARGE		HEAVY PERIODS		PAINFUL PERIODS	
IRREGULAR PERIODS		SPOTTING BETWEEN PERIODS			
GONORRHEA		SYPHILIS		CHLAMYDIA	
VENEREAL WARTS		HERPES		VAGINAL INFECTIONS	
BLEEDING DISORDERS		ANEMIA		BLOOD CLOTS	
ACNE		ECZEMA		PSORIASIS	

OTHER HEALTH PROBLEMS _____

_____

DO YOU HAVE ANY SPECIAL HEALTH CONCERNS YOU WOULD LIKE TO DISCUSS TODAY? _____

_____

_____

FOR OFFICE USE ONLY

REVIEWED AND NOTED BY _____