GynOb associates

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NAME _____ DOB _____

EMERGENCY CONTACT _____ PHONE _____

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

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

DO YOU:
SMOKE _____ HOW MUCH _____ DRINK _____ HOW MUCH _____

DO YOU USE:
CAFFEINE _____ HOW MUCH _____ MARIUJUANA _____ 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 (TAPE, IODINE, INVIRONMENTAL) _____

_____

HEIGHT _____ WEIGHT _____ RECENT WEIGHT LOSS _____ RECENT WEIGHT GAIN _____

NAME AND LOCATION OF PHARMACY _____

PLEASE LIST ALL MEDICINES THAT YOU CURRENTLY TAKE (PRESCRIPTION AND OVER THE COUNTER):

_____ _____

_____ _____

_____ _____

PLEASE LIST ALL SURGERIES YOU HAVE HAD (WITH DATES IF POSSIBLE):

_____ _____

_____ _____

_____ _____

DATE OF LAST PAP SMEAR _____ DATE OF LAST 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 _____