Name:	Date of Birth:
Date of LMP:	

Current Medications (include hormones, herbs, vitamins, nonprescription medicine)	
Name and Dosage	**Name and Dosage**
1.	4.
2.	5.
3.	6.

Allergies (Please include all drug allergies)	
1.	3.
2.	4.

What is your problem today:

Describe your problem- Location/Quality/Severity/Duration/Timing/Context/Modifying Factors/Assoc signs & Symptoms:

System Review
Please answer each category

General	None	Fever	Chills	Sweats	Loss of Appetite	Fatigue
		Generally feel badly	Weight loss			
ENT	None	Earache	Hoarseness	Ringing In ears	Decreased hearing	
		Nasal congestion	Nosebleeds	Sore throat	Difficulty swallowing	
Heart	None	Chest pains	Palpitations	Fainting Spells	Difficulty breathing when lying flat	
		Out of breath exertion	Short of breath at night		Swelling in legs	
Lung	None	Cough	Shortness of breath		Excessive sputum	
Gastro	None	Nausea	Vomiting	Diarrhea	Constipation	
		Change in bowel habits	Abdominal pain	Black/tarry Stools	Jaundice	Vomiting blood
Urinary	None	Leaking urine with cough or sneeze		Leaking urine without cough or sneeze		
		Burning with urination	Blood in urine	Urinary frequency		
Breasts	None	Pain	Lump	Discharge		
GYN	None	Vaginal discharge with itching		Vaginal discharge with odor		
		Other vaginal discharge	Pelvic pain	Abnormal vaginal bleeding		
		Heavy vaginal bleeding	Missed periods	Irregular menses		
Ortho	None	Back pain	Joint swelling	Muscle cramps		
		Muscle weakness	Stiffness	Arthritis		
Skin	None	Rash Itching	Dryness			
Neuro	None	Sensation of room spinning	Weakness	Tingling	Seizures	
		Fainting spells	Tremors			
Psych	None	Depression	Anxiety	Memory loss	Mental disturbance	
		Suicidal thoughts	Hallucinations			
Endocrine	None	Cold intolerance	Heat intolerance	Excessive thirst		
		Excessive hunger	Excessive amounts of urine			
		Significant weight loss	Significant weight gain			

Since Your Last Visit:	**Yes**	**No**	**Please describe:**
Have you been diagnosed with a new medical problem?			
Have you had any surgeries?			
Have you been diagnosed with a new medication allergy?			
Do you have any new family history?			

PATIENT HISTORY Name: **Date of Birth:**

Personal History of Past Illness

Major Illness	Yes (Date)	Major Illness	Yes (Date)
Anemia		Glaucoma	
Arthritis/Joint pain		Headaches (chronic only)	
Asthma		Heart Disease	
Back problems		Hepatitis/Yellow Jaundice/Liver Disease	
Blood Clots in lungs or legs		High Blood Pressure	
Blood Transfusions		High Cholesterol	
Bowel Problems		HIV/Aids	
Broken bones		Kidney Infections/Kidney Stones	
Cancer		Pneumonia/Lung Disease	
Cataracts		Reflux/Hiatal Hernia/Ulcers	
Chickenpox		Rheumatic Fever	
Collagen Vascular Disease (Lupus)		Seizures/Convulsions/Epilepsy	
Depression or Anxiety (circle)		Sexually Transmitted Disease	
Diabetes		Stroke	
Eating Disorders		Thyroid Disease	
Gallbladder Disease		Tuberculosis	
Other			

GYN History

Problem	Yes	No	Problem	Yes	No
Abnormal hair growth			Infertility		
Abnormal Bleeding			Ovarian Cyst		
Abnormal Pap Smear			Osteoporosis		
Breast Problems			Sexual Problems		
Cyst of Vulva			Sexually transmitted disease		
DES Exposure			Uterine Abnormality		
Endometriosis			Urinary Leakage		
Fibroid Uterus			Vaginal/Vulvar Infection		

GYN Surgeries

Surgery	Yes	No	Date/Comments
Abdominal Surgery			
C-Section Delivery			
Dilation & Curettage (D & C)			
Hysterectomy			
Hysteroscopy (out patient)			
Laparoscopy (out patient)			
Vaginal Surgery			
Bartholin Glands Surgery			
Other			

Social History

Preferred Name:	PCP:	Occupation:
Number of people in household:	Single Married Widowed Divorced Separated Living w/ partner	
Education (last grade completed):	Name of significant other:	
Children's Names:		
Seat Belt Use: Always Frequently Occasionally Never		
Occupational Risks: None Biohazard Chemical Physical Labor		
How many days per week do you exercise?	How many packs of cigarettes per day do you smoke?	
How many times per week do you drink alcohol?		
Do you use any of the following? cocaine narcotics marijuana hallucinogens		
Have you ever been or are you currently being physically, verbally or sexually abused?		

Family History- Please check those that apply

Illness	Mother	Father	Sibling	Child	Maternal Grandparent	Paternal Grandparent	Other
Breast Cancer							
Colon Cancer							
Ovarian Cancer							
Alzheimer's Disease							
Birth Defects							
Blood Clots in lungs or legs							
Diabetes							
Drinking or Drug problems							
Endometriosis							
Fibroids							
Heart Disease							
Hepatitis							
High Blood Pressure							
High Cholesterol							
HIV/AIDS							
Mental Illness/Depression							
Osteoporosis							
Stroke							
Tuberculosis							
Other							

Obstetric History

#Total Pregnancies		#Full Term		#Premature		#Elective Abortion	
# Miscarriage		#Ectopic		#Multiples		#Living	

Pregnancy #	**1**	**2**	**3**	**4**	**5**	**6**
Pregnancy Outcome **F**=Full term, **P**=Premature, **M=**Miscarriage						
Delivery Date						
Weeks at Delivery						
Length of labor (hrs.)						
Epidural/Anesthesia						
Delivery Type **V**=Vaginal, **C**=C-section						
Did you have Pre-term Labor?						
Delivery Location						
Who delivered your baby?						
Baby weight?						
Baby Sex?						
Baby Name?						
Complications	**Please check any that apply**					
Gestational Diabetes						
Macrosomia						
Multiple Gestation						
Post Dates						
Post partum hemorrhage						
Pre-eclampsia						
Preterm Delivery						
Other Complications						

Menstrual History	Yes	No
Are you menopausal?		
Have you had a hysterectomy?		
Are you currently late for your period?		
Are you currently pregnant?		
What was your age at your first menstrual period?		
Date of your last menstrual period:		
Are your periods regular (28-30 days)?		
If No what is the interval between your periods? (Number of days)		
How many days of bleeding do you have?		
How many heavy days?		
Do you have pain with your period?		
If Yes- how bad is that pain?	Minimal Mild Moderate Severe	
Do you have a problem with heavy bleeding?		
Do you bleed onto your clothes or bedding?		
Do you bleed after intercourse?		
Do you have bleeding between your periods?		
If Yes- how bad is that bleeding?	Light Medium Heavy	
Occurring?	Early Mid-cycle Late Just prior to menses Random	

Contraception	Yes	No
Are you in a sexual relationship?		
Do you have pain with intercourse?		
Are you trying to become pregnant?		
Do you have questions about sexual function, contraception, or infections?		
Permanent Sterilization Method:	Essure Tubal ligation Vasectomy Hysterectomy None	
What type of contraception do you currently use?	None Essure Tubal ligation Hysterectomy	
	Abstinence Rhythm Method Male withdrawal Condoms Spermicides Diaphragm	
	Norplant Pills Patch Ring Shot IUD-Paragard IUD-Mirena Implanon	
What type of contraception have you previously used?	None Abstinence Rhythm Method	
	Male withdrawal Condoms Spermicides Diaphragm Norplant Pills Patch	
	Ring Shot IUD-Paragard IUD-Mirena Implanon	