Island OB/GYN

12250 E Tamiami Trl, #210, Naples, FL 34113
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Today's Date:_____
Name: _____ DOB: _____
Address: Street _____
City: _____ST: _____Zip: _____
Home #:_____ Mobile: _____
Primary Care Physician: _____
Pharmacy Name & #: _____
Laboratory of Choice: ☐Quest Diagnostics ☐ Lab Corp/ Gynecor

PATIENT HISTORY

HT: _____ WT: _____ BP: _____

MEDICAL HISTORY:

Any medical problems since last examination? Y / N
If yes, explain: _____
_____

MEDICATION ALLERGIES

☐Penicillin/Amoxicillin/Ampicillin ☐Keflex/Cephalosporins
☐ Codeine ☐ Aspirin ☐ Sulfa ☐ Erythromycin
☐_____ ☐_____☐ _____
☐_____ ☐_____☐ _____

GYNECOLOGICAL HISTORY

Any gynecological problems since last examination? Y / N
If yes, explain: _____
First day of last period: _____ Duration: _____ days
Time between periods: _____ days
Contraception? Y / N Name: _____
Sexually Active? Y / N

Last Mammogram: ☐ On File *If not on file please note:*
Date: ___/___/____ Normal? : Y / N Location: _____

Last Pap smear: ☐ On File *If not on file please note:*
Date: ___/___/____ Normal? : Y / N Location: _____

Last Colonoscopy: ☐ On File *If not on file please note:*
Date: ___/___/____ Normal? : Y / N Location: _____

Last Bone Density Scan: ☐ On File *If not on file please note:*
Date: ___/___/____ Normal? : Y / N Location: _____

☐Hysterectomy Date: _____ Ovaries Removed: Y / N

FAMILY HISTORY: Any changes since last examination? Y / N
If yes, explain: *(For example, breast cancer, ovarian cancer, uterine cancer, and/or colon cancer and relation to you)*
_____ Relation: _____
_____ Relation: _____
_____ Relation: _____
_____ Relation: _____

REVIEW OF SYSTEMS:

Abdomen: Diarrhea? Y / N Constipation? Y / N

Genitourinary:
Frequent urination? Y / N Urinary Incontinence? Y/ N

Skin/ Breast:
Lumps in breast Y / N Nipple Discharge? Y / N

Any other Problems?: _____
_____
_____

CURRENT MEDICATIONS TAKEN DAILY/REGULARLY

☐See List

_____ _____ mg
_____ _____ mg
_____ _____ mg
_____ _____ mg
_____ _____ mg
_____ _____ mg
_____ _____ mg

INSURANCE INFORMATION

Insurance Change Since Last Visit? Y / N
If yes, please provide updated information below

Insurance Type- _____

Policy Number- _____

SOCIAL HISTORY

Any changes to since last examination? Y / N
If yes, explain: _____

☐ Cigarettes_____packs/day ☐Alcohol_____drinks/week

Marital Status:

☐Single ☐Married ☐ Separated ☐ Divorced ☐Widowed ☐Other

Exercise Regularly: Y / N

Are you a victim of domestic violence or abuse in your present relationship? Y / N In a past relationship? Y / N

OPERATIONS / SURGICAL / HOSPITALIZATION HISTORY

☐ **No Change / On File**

_____ **YEAR** _____
_____ **YEAR** _____
_____ **YEAR** _____