



Bryan Myers, M.D., PC
Melody Harrison, NP-C
Rebecca Layton, PA-C

Premier Women's Health Center
"Making a difference in women's lives!"
OBGYN offices of:

Ashley De Witt, D.O., PC
Michael Nobles, M.D., PC

Welcome! Please fill out all information to the best of your ability so that we may better serve you!

Medical History

Date: _____ My appointment is with: _____

Patient Name: _____ DOB: _____ Age: _____

Reason for your visit today: _____

Who is your primary care physician? _____

Current Medications: _____

What pharmacy do you use for prescriptions? _____

First day of last period: _____ Do you have regular monthly periods? Y / N

How often do your periods come? _____ Age at first period _____

Periods are: Mild Moderate Heavy Cramps are: Mild Moderate Severe

Drug Allergies: _____

Current birth control: _____

Age at first intercourse: _____ Number of partners (lifetime): _____

Are you having any libido changes? Y / N (please explain) _____

Do you have pain with intercourse? Y / N (please explain) _____

Have you ever had a sexually transmitted disease? Y / N (circle any that apply)

Gonorrhea Chlamydia Herpes Hepatitis B HIV Syphilis Genital Warts PID Trichomonas HPV

Do you use tobacco products? Y / N About _____ cigarettes per day

Do you drink alcohol? Y / N About _____ drinks per week

Are you experiencing any vaginal or urinary:

Discharge Odor Burning Itching Frequency Urgency Loss of Urine

Other: _____

Last Pap smear (month and year): _____ Results: _____

Have you ever had an abnormal pap smear? Y / N

If yes, please give year and any procedures _____



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Last Mammogram (month and year): _____ Results: _____

Have you ever had an abnormal mammogram? Y / N

If yes, please give year and any procedures _____

Do you do monthly breast exams? Y / N / Occasionally

Do you diet? Y / N What type? _____

Do you exercise? Y / N How often & how long? _____

Do you take Calcium? Y / N If so, how much? _____

Notes: _____

Please list all surgeries/hospitalizations

Surgery/reason for hospitalization	Date

Please list all pregnancies

Year	Method of delivery	Gestational age	Sex	Weight	Comments/complications



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Medical Problems

Date of Diagnosis	Medical Problem

Personal & Family History (mark all those that apply)

Disease	Self	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother/Sister	Other
Alcoholism									
Anemia									
Arthritis									
Asthma/lung problems									
Blood clots									
Bloody stools/colon polyp									
Cancer (note type of cancer in box)									
Diabetes									
Heart disease									
High cholesterol									
High blood pressure									
Kidney disease/UTIs									
Liver disease									
Mental illness									
Osteoporosis									
Seizures									
Stomach ulcers									
Stroke									
Thyroid disease									
Tuberculosis									
Other									



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Review of systems

Please indicate if you are having any current problems in the following areas by marking an X in the appropriate column.

General wellness	Y ___ N ___	Muscle/joints/bones	Y ___ N ___
Eyes	Y ___ N ___	Skin	Y ___ N ___
Ear, nose, throat	Y ___ N ___	Neurological	Y ___ N ___
Heart/circulation	Y ___ N ___	Psychiatric	Y ___ N ___
Lungs/breathing	Y ___ N ___	Endocrine	Y ___ N ___
Stomach/digestion	Y ___ N ___	Blood/lymph	Y ___ N ___
Reproduction/urinary	Y ___ N ___	Allergies	Y ___ N ___

Completed by: _____ Signature: _____ Date: _____