Island OB/GYN

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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: ____
____

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?: ___________________________________
____
____

MEDICATION ALLERGIES

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

CURRENT MEDICATIONS TAKEN DAILY/REGULARLY

☐See List

______________________________ _________ mg
______________________________ _________ mg
______________________________ _________ mg
______________________________ _________ mg
______________________________ _________ mg
______________________________ _________ mg
______________________________ _________ mg
______________________________ _________ mg
______________________________ _________ mg
______________________________ _________ mg

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** __________