Women's Lifecycles, PC

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Obstetrics *Gynecology*

The following information is very important to your health.
Please take the time to fully and accurately fill out this form

Name:_____ Age_____ Today's Date:_____
Date of Birth _____

Primary Family Physician: _____ Pharmacy: _____
Previous Gynecologist: _____
Medical Problems: _____
(please list) _____
_____
_____

List all medications (prescription and over-the-counter) you are presently taking:
_____
_____
_____
_____
_____
_____

Allergy to medications: _____
_____
_____

Past surgeries (include year and hospital where performed):_____
_____
_____
_____
_____

Height:_____ Weight: _____ Referred by:_____

MEDICAL HISTORY If you have any of the following, please check all that apply:

___ Asthma
___ Heart murmur
___ Phlebitis
___ Seizures
___ Migraines
___ Liver disorders/hepatitis
___ Gallbladder problems
___ Hypertension
___ Anemia
___ Depression
___ Stroke
___ Osteoporosis
___ Thyroid problems
___ Diabetes

FAMILY HISTORY: (Please list which relative.)

Yes	No	
___	___	Breast cancer: _____
___	___	Cancer: Uterus_____ Cervix_____ Ovary_____
___	___	Colon_____ Skin/melanoma_____
___	___	Other cancers: _____
___	___	High blood pressure: _____
___	___	Heart attacks: _____
___	___	Strokes:_____
___	___	Diabetes: _____
___	___	Osteoporosis:_____

PLEASE COMPLETE OTHER SIDE

Mother's age or age at death: _____ Health problems: _____

Father's age or age at death: _____ Health problems: _____

Medical problems of brothers & sisters:_____

_____

Husband's age:_____ Health problems: _____

Children's ages: _____

List any health _____

problems) _____

_____

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SOCIAL HISTORY

Yes No

___ ___ Do you smoke? How many packs per day?_____

___ ___ Do you drink alcohol? How often? _____ What? _____

___ ___ Do you ever used street drugs? Which ones? _____

___ ___ Have you or any of your sexual partners used IV drugs?_____

___ ___ Are you experiencing abuse (currently or in your past)? Physical____ Sexual____ Emotional____

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GYNECOLOGIC HISTORY

How old were you with your first menstrual period? _____

How often do you get periods? _____ days

How many days do you bleed? _____ Heavy?_____ Moderate?_____ Light?_____

When was the first day of your latest period? _____

When was your last pap smear? _____ Have you ever had an abnormal pap smear? _____ When? _____

Yes No

___ ___ Have you ever had an infection in your pelvis?

___ ___ Have you ever had any sexually transmitted diseases (herpes, gonorrhea, genital warts, chlamydia, syphilis)?

If yes, which ones:_____

_____

_____

___ ___ Do you currently have a sexual partner? Male____ Female____ Male & Female____

___ ___ Are you having intercourse?_____

___ ___ How many sexual partners have you ever had?_____

___ ___ Were you or your husband sterilized? No____ Yes____ Myself_____ Husband

What are you currently using for contraception? (including sterilization)

_____

_____

_____

OBSTETRICAL HISTORY

List in order all pregnancies, including miscarriages, abortions, stillbirths and live births:

	Year	Hospital	Type of Delivery (vaginal, C/Section abortion, miscarriage)	Baby's Weight, Sex, Problems	Breast or Bottle Fed
1)					
2)					
3)					
4)					
5)					
6)					

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Yes No

Blood type: _____

___ ___ Have you had Rubella or MMR vaccine? If yes, what year?

___ ___ Do you examine your breasts?

___ ___ Have you ever had a mammogram? When:_____ Where: _____

Normal:_____ Abnormal:_____

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How did you hear about our practice? _____

What is the reason for your visit today? _____

_____

(If anything other than routine annual gynecologic exam, does your referral form indicate these same reasons/problems?)

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform necessary services I may need.

Patient Signature_____ Date_____

Physician/Nurse Practitioner _____ Date_____
signature upon review

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