________________________________ _____________________________ ________________
Patient's Printed Name *Date of Birth* *Date*

ADVANCED OBSTETRICS & GYNECOLOGY

"Comprehensive Healthcare for Women"

In order to expedite your visit with us at your appointment and ensure that we address your issues appropriately, we ask that you please complete this form.

In a few words, tell us what brings you to our office:
____
____

Do you have any cultural or religious beliefs that might affect your care? ☐ *No* ☐ *Yes - please explain below:*
____
____

Do you have any ***chronic medical conditions****?* ☐ *No* ☐ *Yes - please list below:*
____
____
____
____

Please list all of the ***surgeries*** *you have had along with the month/year if known:*
____
____
____

Immunizations and most recent date:
- ☐ *Flu Shot* *Date:* ______________
- ☐ *Gardasil/HPV* *Date:* ______________
- ☐ *Pneumonia* *Date:* ______________
- ☐ *Tdap (Tetanus & Pertussis)* *Date:* ______________
- ☐ *Tetanus* *Date:* ______________
- ☐ *Zostavax (Shingles)* *Date:* ______________

OB/GYN History:
- *Age of first menses:* ______
- *Date of last menstrual period:* __________
- *Number of Pregnancies:* _____
- *Births:* _____
- *Miscarriages:* _____
- *Terminations:* _____

Pregnancy Details:

	Date of Birth	Type of Delivery	Gender	Birth Weight	Hospital	Child's Name	Complications during Pregnancy and/or With Delivery
1							
2							
3							
4							
5							
6							

_______________________________ _____________________________ ________________

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Last Mammogram *Date:* _____________
Last Bone Density Study *Date:* _____________
Last Colonoscopy *Date:* _____________
Last Pelvic Ultrasound: *Date:* _____________
Last Screening bloodwork *Date:* _____________

Last Pap Smear *Date:* _____________
☐ *Normal* ☐ *Abnormal*
Any history of an abnormal pap? ☐ *No* ☐ *Yes*
If yes, please detail the level of abnormality if known, date and any treatment: _______________________
____

It would be very helpful if you are able to obtain copies of your last testing and bring it with you to your appointment.

Allergies: *List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.*

Allergy *Reaction*
1. ___________________________ _________________________
2. ___________________________ _________________________
3. ___________________________ _________________________
4. ___________________________ _________________________
5. ___________________________ _________________________

☐ *I have no known drug or food allergies.*

Medications: *Please list all the medications you are taking. Include prescribed medications and over-the-counter medications and supplements.*

	Medication Name:	*Strength:*	*Frequency Taken:*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Family History *– please document any significant medical conditions among your BLOOD relatives:*
**Please include any heart disease, cancer (with age of diagnosis), hypertension, diabetes, osteoporosis, stroke, genetic disease, mental illness, arthritis, and any blood, colon, kidney or thyroid disease.*

Relation	*Alive ?*	*Current age or Age deceased*	*Significant Health Problem(s)**
Mother:			
Father:			
Brother/Sister:			
Brother/Sister:			
Brother/Sister:			
Maternal Grandmother:			
Maternal Grandfather:			
Paternal Grandmother:			
Paternal Grandfather:			

_________________________________ Patient's Printed Name

______________________________ Date of Birth

_________________ Date

Relation	Alive ?	Current age or Age deceased	Significant Health Problem(s)*
Other:			
Other:			
Other:			
Other:			
Other:			

Smoking History: ☐ *Never* ☐ *Former** ☐ *Current Smoker**

* Please complete	Age started:	Age stopped:	Quantity:		Frequency:	
	_____	_____	_____ Packs	_____Cigarettes	☐ Daily	☐ Weekly

Do you exercise regularly? ☐ *Never* ☐ *Occasionally* ☐ *____ times/week* ☐ *Daily*
Do you consider your diet: ☐ *Well-balanced* ☐ *Fair* ☐ *Poor*
Do you have any diet restrictions? ☐ *No* ☐ *Yes, _________________________________*
Do you consume alcohol? ☐ *No* ☐ *Yes (what and how often) ______________________*
Caffeine Intake (coffee, teas, soda, etc.) ☐ *None* ☐ *Yes, _____ cups/daily*
Do you have any history of domestic violence? ☐ *No* ☐ *Yes*
Are you aware of how to prevent STD's? ☐ *Yes* ☐ *No*
Do you know how to do self-breast exams? ☐ *Yes* ☐ No
Were you born in the United States? ☐ *Yes* ☐ No, ______________________________
Any recent travel out of the country (within the last year)? ☐ *No* ☐ *Yes, ___________________________*

If you are experiencing any of the ***symptoms*** *listed below, please check them off.*

- ☐ *Fatigue*
- ☐ *Fever*
- ☐ *Night sweats*
- ☐ *Weight gain*
- ☐ *Weight loss*
- ☐ *Hearing loss*
- ☐ *Visual changes*
- ☐ *Chronic cough*
- ☐ *Known tuberculosis exposure*
- ☐ *Wheezing*
- ☐ *Chest pain*
- ☐ *Palpitations*
- ☐ *Abdominal pain*
- ☐ *Blood in stools*
- ☐ *Change in stools*
- ☐ *Constipation*
- ☐ *Diarrhea*
- ☐ *Heartburn*
- ☐ *Loss of appetite*
- ☐ *Nausea*
- ☐ *Vomiting*
- ☐ *Burning with urination*
- ☐ *Blood in urine*
- ☐ *Leaking of urine*
- ☐ *Painful periods*
- ☐ *Painful intercourse*
- ☐ *Hot flashes*
- ☐ *Irregular menses*
- ☐ *Vaginal discharge*
- ☐ *Breast discharge*
- ☐ *Breast lump*
- ☐ *Hair loss*
- ☐ *Hives*
- ☐ *Mole changes*
- ☐ *Rash*
- ☐ *Dizziness*
- ☐ *Headache*
- ☐ *Memory loss*
- ☐ *Anxiety*
- ☐ *Depression*
- ☐ *Insomnia*
- ☐ *Back pain*
- ☐ *Joint pain*
- ☐ *Muscle weakness*
- ☐ *Bruising easily*
- ☐ *Swollen lymph nodes*
- ☐ *Environmental allergies*
- ☐ *Seasonal allergies*
- ☐ *Other: _____________________*

Please circle any of the symptoms you have checked off above, if you would like to discuss them with your physician at your appointment.

____
Patient Signature