GENESYS WOMEN SERVICES, P.A.

Obstetrics/Gynecology

Name: _____

Referring MD (include medical specialty): _____

Have you ever been admitted to a hospital? _____

_____

Describe any surgery you have had? _____

_____

List any current medical problems: _____

_____

List all medications (prescription & non-prescription) you take regularly: _____

_____

List any allergies you have: _____

_____

Please check if you now have or have ever had any of the following:

- ☐ High Blood Pressure
- ☐ ☐ Blood transfusion
- ☐ Kidney/bladder problems
- ☐ Heart disease/mitral valve prolap
- ☐ Frequent headaches
- ☐ Stomach/intestinal problems/ulcer
- ☐ Rheumatic fever/heart murmur
- ☐ Diagnosed migraines
- ☐ Gallbladder disease
- ☐ High cholesterol/blood fats
- ☐ Epilepsy/convulsion
- ☐ Breast lumps/discharge
- ☐ Stroke
- ☐ Numbing/tingling
- ☐ Measles ☐ German measles
- ☐ Lung problems/tuberculosis
- ☐ Liver disease/hepatitis
- ☐ Mumps ☐ Chicken pox
- ☐ Shortness of breath/chest pain
- ☐ Jaundice
- ☐ Hot flashes
- ☐ Asthma
- ☐ Mononucleosis
- ☐ Depression/emotional problems/anxiety
- ☐ Pneumonia
- ☐ Diabetes
- ☐ Sleep disorders
- ☐ Phlebitis/clots in vein
- ☐ Thyroid disease
- ☐ Problems with balances, hearing taste, smell
- ☐ Varicose veins
- ☐ Fatigue/intolerance to hot or cold
- ☐ Eating disorders
- ☐ Blood problems/anemia
- ☐ Cancer
- ☐ Sickle cell disease

If you smoke, how many packs per day? _____ How many years have you been smoking? _____

How many cups of coffee, tea, or other beverages containing caffeine do you drink daily? _____

On average, how many alcoholic beverages do you dink each week? _____ Drug use? _____

How often do you exercise? _____ What is your cholesterol? _____

Are you adopted? ☐ Yes ☐ No

Indicate who of your blood relatives (parents, grandparents, brothers, or sisters) have or had any of the following problems

_____Diabetes _____High blood pressure _____Broken bones after age 35
_____Cancer _____Stroke _____ Heart attack/coronary artery disease & age at which it occurred
_____Breast Cancer _____High cholesterol/blood

Age when period began _____ Periods come every _____day Periods last _____days
First day last period began_____ Do you have cramps? _____ Do you take medication for cramps? ____
Your periods are now: ☐ regular ☐ irregular ☐absent ☐# of lampoons _____ and/or pads _____ used on heaviest flow
Have vou ever missed a period for 3 months or longer (except when pregnant)?

What method of birth control are you using? How long? _____
Check any other methods you have used:
☐Pills ☐diaphragm ☐sponge ☐partner sterile ☐condom ☐ foam/other spermicide
☐ I.U.D ☐cervical cap ☐ self-sterile ☐withdrawing ☐rhythm/natural family planning

If you want birth control now, indicate which method
Have you had vaginal intercourse without birth control since your last period? ☐ Yes ☐ No

Is this your first pelvic exam? _____ Date of last pelvic exam? _____
Date of last Pap smear? _____ Performed by:_____
Have you ever had an abnormal Pap smear?
Do you perform breast self-examination? _____ Have you had a mammogram? _____
Do you have abnormal discharge or itching from the vagina?
Have you ever involuntary lost urine? _____
Have you ever been on hormone replacement therapy?
Check is you ever had: ☐ herpes ☐ gonorrhea ☐venereal warts ☐ pelvic inflammatory disease
☐ Syphilis ☐chlamydia ☐ vaginal infections ☐positive HIV (AIDs)

Do you have any questions about sexual relationships that you would like to discuss today? -
Are your partners: ☐male ☐female ☐both ☐numerous sexual partners in past year: _____

How many times have you been pregnant? Your age at first pregnancy?
Number and dates of _____ full-term pregnancies_____ Cesarean Section_____ abortions_____
miscarriages premature deliveries_____ stillbirths_____
List your children month and year of birth with, sex and birth weight
1.----------

2. ----------
3.----------
4.----------5.

If they have any birth injuries or genetic problems. Describe:

Print Signature: _____ Date: _____

Physician Signature: _____ Date: _____