

## Women Physicians Ob/Gyn Medical Group

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
 Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_ First day of your last period: \_\_\_\_\_

I. **List any problems or concerns you are having:** \_\_\_\_\_  
 \_\_\_\_\_

II. List other physicians you have seen **since your last visit.**  None  
 Name of doctor                      Date                      Problem  
 \_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_  
 \_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_  
 \_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_

III. Surgeries or hospitalization **since your last visit.**  None  
 Type of surgery or reason for hospitalization      Date                      Doctor                      Name of Facility  
 \_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_  
 \_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_

IV (A) Current contraception:  None  Vasectomy  Tubal Ligation  Hysterectomy  IUD  Condoms  
 Diaphragm  Depo-Provera  Implanon  Pills: Brand \_\_\_\_\_  Other \_\_\_\_\_  
 (B) Number of sexual partners in last year \_\_\_\_\_  male  female  both  
 (C) Current medications and dosage:  None \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(D) Medication Allergies:  None \_\_\_\_\_

V. Since your last visit, have you had a problem with:

	Yes	No		Yes	No
1. Abnormal periods	<input type="checkbox"/>	<input type="checkbox"/>	11. Black or bloody stools	<input type="checkbox"/>	<input type="checkbox"/>
2. Bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>	12. Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>
3. Bleeding after intercourse	<input type="checkbox"/>	<input type="checkbox"/>	13. Frequent urinary infections	<input type="checkbox"/>	<input type="checkbox"/>
4. Severe pain with periods	<input type="checkbox"/>	<input type="checkbox"/>	14. Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
5. Breast mass or lumps	<input type="checkbox"/>	<input type="checkbox"/>	15. Leakage of urine	<input type="checkbox"/>	<input type="checkbox"/>
6. Breast secretions	<input type="checkbox"/>	<input type="checkbox"/>	16. Crushing chest pain	<input type="checkbox"/>	<input type="checkbox"/>
7. Blood from nipples	<input type="checkbox"/>	<input type="checkbox"/>	17. Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
8. Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	18. Shortness of breath at rest	<input type="checkbox"/>	<input type="checkbox"/>
9. Extreme fatigue	<input type="checkbox"/>	<input type="checkbox"/>	19. Change in headaches	<input type="checkbox"/>	<input type="checkbox"/>
10. Change in skin mole	<input type="checkbox"/>	<input type="checkbox"/>	20. Severe depression	<input type="checkbox"/>	<input type="checkbox"/>

**For Doctor's Use Only**

VI. Do you:

	Yes	No		Yes	No
Exercise regularly	<input type="checkbox"/>	<input type="checkbox"/>	Use recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>
Do monthly breast exams	<input type="checkbox"/>	<input type="checkbox"/>	Smoke	<input type="checkbox"/>	<input type="checkbox"/>
Have questions about domestic or sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	Drink alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Wear seatbelts	<input type="checkbox"/>	<input type="checkbox"/>	Amount _____		
			Wear helmets when you bike	<input type="checkbox"/>	<input type="checkbox"/>

VII. When was your last cholesterol? \_\_\_\_\_ Where? \_\_\_\_\_  
 When was your last mammogram? \_\_\_\_\_ Where? \_\_\_\_\_  
 When was your last tetanus? \_\_\_\_\_

VIII. Family history: Yes No

1. Since your last visit, have there been any deaths in your family?
2. Since your last visit, has there been any significant illness in the family?
3. Family history of cancer of the  breast  ovary  uterus  cervix  colon?
4. Family history of  osteoporosis  diabetes  heart attacks    
 high cholesterol  Alzheimer's  thyroid disease

