EAST COOPER OB/GYN

PEDIATRICS AND ADOLESCENT GYNECOLOGY

Assessment and Initial History

Our practice desires to provide you comprehensive health care, both preventative and maintenance within an environment designed to meet the medical, emotional, and educational needs of girls and women. Therefore, we ask that you fill out this form as thoroughly as possible, as this information is important to aid us in your health care.

Name: _____ Age: _____ Date: _____

Referred by: _____

Person Filling out Form: _____ Relationship to Patient: _____

Telephone Numbers: (home) _____ (office) _____ (cell) _____

Reason for Visit TODAY: _____

_____

Allergies: _____

Recent or Current Medications (dose if known): _____

_____

List Any Hospitalizations and Surgeries in the Past: _____

Has patient received treatment or evaluation for any of the following?

_____ Developmental Delays _____ Depression or Emotional Problems

_____ Sexual Abuse or Assault _____ Eating Disorder

_____ Child Abuse or Neglect _____ Substance Use or Addiction

Family History: Please check the following conditions and which family member has the condition below

_____ Diabetes _____ Cancer _____ High Cholesterol _____ Genetic Disorder

_____ Bleeding or Clotting Abnormality _____ Birth Defect or Physical Handicap _____ Mental Handicap

_____ Other (please specify) _____

Social History:

School: _____ Grade: _____

Who lives in the same household with the patient: _____

Review of Systems

Please circle any symptoms that the patient has had within the past 3 months.

Constitutional: Change in weight, fever, feeling tired, run down

Skin: Skin changes, rash, new lesion

Eyes: Change in vision, eye irritation, redness

ENT: (ears, nose, throat) Changes in hearing, ear pain, mouth sores, congestion, runny nose

Cardiovascular: Chest pain, irregular heartbeat, passing out

Respiratory: Feeling short of breath, difficulty breathing, wheezing, coughing

Gastrointestinal: Stomach pain, nausea, vomiting, significant diarrhea or constipation, blood in stools

Urinary: Burning or pain with urination, frequent urination, blood in urine

Musculoskeletal: Joint pain, muscle pain, joint or muscle swelling, recent fractures

Neurological: Headaches, seizure, muscle weakness, numbness

Psychiatric: Change in mood, feeling nervous, sad, not enjoying activities that are usually fun

Endocrine: No change in appetite or thirst, heat or cold intolerance

Lymphatic: Swollen or tender lymph nodes or "glands"

Immunizations:

Is your child up to date with all immunizations? _____

Date of last immunization and what received: _____

Gynecological History:

Period Started: YES NO If yes, when? _____ Last period: _____

Period comes every _____ days? Regular / Irregular (please circle)

Period flow: clots heavy moderate light spotting

Period pain: severe moderate mild none

Spotting between periods: YES NO

Please use this space to add any additional information or list specific concerns.

_____

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