East Cooper OB/GYN

Women Devoted to Women

New GYN Patients

Name: _____ **Date:** _____

Preferred Name (Nickname): _____ **Date of birth**_____

Occupation: _____ **Age:** _____

Referred by (physician, patient, friend, etc.):

_____

Primary Care Physician: _____

I am here today for a (n): _____ **annual exam** _____ **problem visit**

Your Pap Will Be Sent to Gen Path

Would you like a chaperone present for a pelvic exam? *(please initial)* _____Yes _____No

Please list any ALLERGIES:

_____

List any <u>medications</u> you are currently taking:

Name of medication	Dose (mg)	Refill needed (please circle)
_____		**Yes / No**
_____		**Yes / No**
_____		**Yes / No**
_____		**Yes / No**
_____		**Yes / No**

Pharmacy Preference:_____

LMP (last menstrual period):_____

Current form of birth control:_____

<u>Medical and Surgical History:</u>

Please list any ongoing **medical problems** for which you regularly see a doctor or take medication:

_____

_____

Have you ever been told that you have had MRSA (methicillin resistant staph aureus) infection?

Yes / No If yes, when?_____

Please list any **surgeries** you have had:

Operation	Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Date of last pap smear: _____

Have you ever had an abnormal pap smear: *No* *Yes*

If "yes" when: _____ What treatment was required: None Colposcopy Cryo LEEP Cone

Please circle any of the following diseases you have had or for which you have been treated:

Gonorrhea *Chlamydia* *Syphilis* *Herpes* *Trichomonas* *Venereal Warts*

Family History:

Please list any relatives with the following medical problems:
(please list which family members)

Breast cancer _____

Ovarian cancer _____

Uterine cancer _____

Colon cancer _____

Other cancers _____

Diabetes _____

High blood pressure_____

Lung disease_____

Kidney problems_____

Blood disorders_____

Thyroid disease_____

Heart disease_____

Stroke _____

Blood clots _____

Other (please list)_____

Social History:

Marital Status *single* *stable relationship (not married)* *married* *separated* *divorced* *widowed*

Smoking status: *Never* *Former* *Current everyday* *Current someday*

*If former smoker, when did you quit?*_____ *For how long did you smoke?* _____

If current smoker, how much do you smoke per day? _____ *For how many years?*___

Have you ever used: *E-cig/vaping* *Smokeless tobacco* *Chewing tobacco*

Do you drink alcohol? *No* *Yes* How many drinks per week? _____

How many days in the past year have you had **heavy** alcohol consumption? _____

Do you use illegal drugs? *No* *Yes* (please specify) _____

Obstetrical History Please list each pregnancy and outcome:

Year	Full / Preterm	Type of Delivery Abortion / Miscarriage Vaginal / C-section	Gender	Birth Weight	Complications
1st _____	Full / Pre	A / M / V / C	M / F	_____lbs ____oz	_____
2nd _____	Full / Pre	A / M / V / C	M / F	_____lbs ____oz	_____
3rd _____	Full / Pre	A / M / V / C	M / F	_____lbs ____oz	_____

Gynecologic History: Age at first menses _____ Age at menopause _____

Frequency of menses, every _____days Bleeding in between menses? Y / N

Duration of menses, _____days

Amount of menses: *spotting light moderate heavy clots*

Pain with menses: *none mild moderate severe*

Are you currently sexually active? Y / N

Number of partners in past year: _____ Gender of partners: *Male Female Both*

Pain with intercourse? Y / N Vaginal dryness? Y / N

Decreased libido? Y / N Vaginal bleeding after intercourse? Y / N

Have you been vaccinated against HPV *(human papilloma virus / Gardasil)***?** Yes No

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Mood Screening*:*

During the past two weeks how often have you been bothered by the following:

Little interest or pleasure in doing things:

Not at all / Several days / More than half the days / Nearly every day

Feeling down, hopeless, or depressed:

Not at all / Several days / More than half the days / Nearly every day

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Health Maintenance:

Have you ever had a mammogram? Y / N Date of most recent: _____

Have you ever had a bone density test? Y / N Date of most recent: _____

Have you ever had a colonoscopy? Y / N Date of most recent: _____

Any specific concerns or issues you wish to address:

_____

_____