Patient History Intake (OBG)

Today's Date:

Patient Name: _____ **Birth Date:** _____

How did you come to visit our office? Yellow Pages Ad (specify which phonebook): _____

Referred by a friend: _____ Referred by family member: _____

Sent by my physician, Dr. _____ Other (please specify): _____

Please describe the reason(s) for this visit: _____

_____

Do you have any questions, problems, symptoms or concerns that you would like to discuss with us today? _____

LIST ANY MEDICATIONS you are taking, including non-prescription drugs, vitamins, herbals: _____

Review of Systems:

Do you have now or have you had persistent symptoms within the past year?

Const Weight Gain/Loss .....no yes
Fever.....no yes
Fatigue .....no yes

Eyes Dry eyes .....no yes
Vision changes.....no yes

ENT Mouth sores .....no yes
Sore throat.....no yes
Ringing in ears .....no yes
Sinus headaches .....no yes

Resp Persistent cough .....no yes
Coughing blood.....no yes
Wheezing.....no yes
Shortness of breath.....no yes

CV Shortness of breath with activity .....no yes

Difficulty breathing while lying down .....no yes

CV Chest pain .....no yes
Rapid heart beat.....no yes
Swollen hands/feet ....no yes

Skin Skin rash .....no yes
Painful breasts.....no yes
Breast lumps .....no yes
Nipple discharge.....no yes

GI Persistent diarrhea .....no yes
Bloody stools.....no yes
Nausea, vomiting .....no yes
Constipation .....no yes
Bloating/gas.....no yes
Abdominal pain.....no yes

ALL Hives, blisters.....no yes
Red, itchy eyes .....no yes

Renal Persistent sore throat..no yes
Pain burning w/urination no yes
Do you have to strain/push when urinating no yes
Previous kidney/bladder Infection no yes

Psych Depression .....no yes
Mood swings.....no yes
Sleep Disturbances.....no yes

Neuro Seizures .....no yes
Frequent headaches ...no yes
Dizziness .....no yes
Numbness .....no yes

MSK Joint or muscle pain .....no yes
Muscle weakness .....no yes

Lymph Swollen lymph nodes ...no yes

Heme Easy bleeding .....no yes
Easy bruising .....no yes

Endo Night sweats.....no yes
Hot/cold intolerance ...no yes

_____

Other

_____

Hot Flashes _____.....no yes

Pain w/ Inter course _____no yes

Female Genitourinary (ROS):

All patients:

Date of last pap smear? _____
Any abnormal pap smears? ..... no yes
Date of last mammogram _____
Number or pregnancies: _____

Number of live births: _____

Did you breast feed? ..... no yes
Monthly breast self-exams? ..... no yes
Any problem w/leaking urine? ... no yes
Are you sexually active?..... no yes

Age period began _____
Date of last period: _____
Frequency of periods: _____
Average # of days: _____
Method of contraception: _____

Satisfied with this method?.....no yes

Menstrual Flow is usually: _____
Are your periods usually painful no yes
Do you clot with your periods no yes

Menopausal Patients only:

Do you use hormones? ...no yes
If so, type: _____
Any vaginal bleeding? ...no yes
Date of last colonoscopy? _____
When did you menstrual periods stop? _____

Have you had a Bone Density test? .....no yes

Drug allergies (ROS): _____

Have you EVER had a sexually transmitted infection? no yes
If yes, name of Infection _____

Past Medical History:

Have you ever had the following?

Heart disease	no	yes	Cancer	no	yes	Stomach Ulcer	no	yes
Arthritis	no	yes	Glaucoma	no	yes	Kidney disease	no	yes
Rheumatic Fever	no	yes	Asthma	no	yes	Thyroid Disease	no	yes
Anemia	no	yes	AIDS or HIV+	no	yes	Bleeding tendency	no	yes
Tuberculosis	no	yes	Stroke	no	yes	Mitral Valve Prolapse	no	yes
Diabetes	no	yes	Hepatitis	no	yes	High Blood Pressure	no	yes
Allergies	no	yes	Blood Clotting Disorder	no	yes			

Past Surgical History:

Have you ever had the following?

Hysterectomy	no	yes	Breast biopsy	no	yes	Colposcopy	no	yes
Surgery on tubes/ovaries	no	yes	Breast cyst aspiration	no	yes	Urologic	no	yes
Cesarean delivery	no	yes	Mastectomy	no	yes	Other: _____		

Please list any other previous surgeries or any other major illnesses and dates: _____

_____

Previous Pregnancies:

Year of Birth | Length of Pregnancy In Months | Birth Wt. | Sex | # of hours In Labor | Delivery Type

_____

_____

Miscarriages:

Year | How far along In months | Cause | Was a D&C performed | Complications

_____

_____

Family History:

Has any blood relative ever had the following?

Breast Cancer	no	yes	Stroke	no	yes	Kidney disease	no	yes
Ovarian cancer	no	yes	High blood pressure .	no	yes	Tuberculosis	no	yes
Colon cancer	no	yes						
Cervical cancer	no	yes	Heart Disease	no	yes	Depression	no	yes
						Melanoma	no	yes
Uterine caner	no	yes	Diabetes	no	yes	Thyroid Disease	no	yes

Social History:

Marital Status: S M W D

Occupation: _____

Weight _____ Height _____

Do you exercise? No yes

Type: _____

How often? _____

Smoking (type & amount per day) _____

If former smoker, date quit: _____

Have you ever been sexually abused? No yes

Have you ever been physically or mentally abused? No yes

Do you get calcium in your diet? No yes

Supplements: _____

Alcohol (type and amount per week): _____

Do you use marijuana, cocaine or other drugs? No yes

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____ _____

Signature of patient or parent if minor | Date