



# Initial/Annual Visit or Consultation

**PATIENT: PLEASE FILL IN THE FOLLOWING**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: (work) \_\_\_\_\_ (home) \_\_\_\_\_ (cell) \_\_\_\_\_ Best number to reach you: \_\_\_\_\_

How were you referred/informed of our office? \_\_\_\_\_

Primary Care MD: \_\_\_\_\_

REASON FOR THIS VISIT:      Annual gynecologic exam  
   Gynecologic problem

Please list any **MEDICAL PROBLEMS** for which you see a doctor. (Example: asthma, depression, diabetes.)  
Please include the name of the doctor that cares for you.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list prior **SURGERIES, HOSPITALIZATIONS, OR SERIOUS ILLNESS:**

<u>Date</u>	<u>Event</u>
_____	_____
_____	_____
_____	_____
_____	_____

Please list current **MEDICATIONS** with dosing (include nonprescription meds, vitamins, herbs & supplements):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any **ALLERGIES** to medications or latex (describe your reaction, i.e., hives, nausea, etc.):

\_\_\_\_\_  
\_\_\_\_\_

### **PREGNANCY HISTORY:**

Number of pregnancies: _____	Ectopic Pregnancies: _____
Preterm births: _____	Number of vaginal births: _____
Miscarriages: _____	Number of C-sections: _____
Abortions: _____	Number of living children: _____

Please list any prior pregnancy complications: \_\_\_\_\_

### **GYN HISTORY:**

Age started menstruation: \_\_\_\_\_

Are you currently sexually active?      No    Yes

Do you use birth control?                No    Yes     Date of last Pap smear: \_\_\_\_\_

What do you currently do to prevent pregnancy? \_\_\_\_\_     Date of last mammogram: \_\_\_\_\_

Have you ever had an ABNORMAL Pap?    No    Yes

Have you ever had a sexually transmitted disease?    No    Yes     Date of last bone density: \_\_\_\_\_

Have you ever had an abnormal mammogram?    No    Yes

Have you experienced physical or sexual abuse?    No    Yes     Date of last colonoscopy: \_\_\_\_\_

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**SOCIAL HISTORY:**

Are you:  Married  Divorced  Single  Widowed  
 Highest Level of Education: \_\_\_\_\_  
 Sexual Preference:  Male  Female  
 Ethnic Background:  White  African American  Hispanic  Asian  Other \_\_\_\_\_

Are you employed?  No  Yes What Occupation? \_\_\_\_\_

Do you use:  
 Cigarettes:  No  Yes #/day \_\_\_\_\_ Years of use \_\_\_\_\_  
 Alcohol:  No  Yes #/day \_\_\_\_\_ Years of use \_\_\_\_\_  
 Illegal drugs:  No  Yes Years of use \_\_\_\_\_

**FAMILY HISTORY:**

	Mother	Father	Other relative(s)
<input type="checkbox"/> Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Uterine cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Ovary cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Bowel Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Other: _____			_____

Mother:  Living  Deceased  
 Father:  Living  Deceased  
 Brothers: # Living \_\_\_\_\_ # Deceased \_\_\_\_\_  
 Sisters: # Living \_\_\_\_\_ # Deceased \_\_\_\_\_

Please list AGE & CAUSE of death if applicable:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**REVIEW OF SYSTEMS:** (check if applies)

- 1. GENERAL SYMPTOMS  None
  - Weak, tired all the time
  - Fevers
  - Lack of appetite
- 2. EYES  None
  - Visual changes
- 3. EARS, NOSE, MOUTH  None
  - Sinus trouble
  - Headaches
  - Ear aches/pain
- 4. CARDIOVASCULAR (HEART)  None
  - Chest pains
  - Difficulty breathing or wheezing
  - Swelling of the feet
  - Heart pounding or irregular heartbeat
- 5. PULMONARY (LUNGS)  None
  - Cough
  - Problems breathing
- 6. GASTROINTESTINAL  None
  - Diarrhea
  - Constipation
  - Leaking stool
  - Nausea or vomiting
  - Stomach pains

- 7. URINARY  None
  - Blood in urine
  - Burning with urination
  - Frequent or Urgency with urination
  - Leakage of urine
  - Incomplete emptying after urination
  - Kidney stones
- 8. MUSCULOSKELETAL  None
  - Muscle weakness
  - Joint pains (arthritis)
  - Back pain
- 9. ENDOCRINE  None
  - Hot flashes
  - Thyroid gland problems
- 10. HEMATOLOGIC & LYMPHATIC  None
  - Bruising/bleeding easily
  - Enlarged lymph glands
- 11. GYNECOLOGIC  None
  - Irregular vaginal bleeding
  - Unusual vaginal discharge
  - Pelvic pain
  - Pain with sexual intercourse
  - Lumps/bumps
  - Concerns about STDs

Other: \_\_\_\_\_

Physician signature and date: \_\_\_\_\_