

Women's Medical Associates of Nashville

New Patient Information Form

Name _____ Age _____ Date of Birth _____ Date _____

REASON FOR VISIT: ANNUAL EXAM PROBLEM VISIT (please describe) _____

PAST MEDICAL HISTORY:

Please list your past and current MAJOR MEDICAL ILLNESSES: NONE _____

1. _____ 3. _____
 2. _____ 4. _____

When was your last PAP SMEAR? _____

Do you have any history of ABNORMAL PAP SMEARS? YES NO

Have you ever had a BONE DENSITY STUDY? YES NO
 If YES, when was your last one? _____ was it normal? _____

Have you ever had a MAMMOGRAM? YES NO
 If YES, when was your last one? _____ was it normal? _____

Have you gone through MENOPAUSE? YES NO
 If YES:

- How old were you when you stopped having periods? _____
- Are you on any HORMONE REPLACEMENT THERAPY? YES NO
- Do you have any significant MENOPAUSAL SYMPTOMS? YES NO
 - HOT FLASHES NIGHT SWEATS VAGINAL DRYNESS OTHER _____

Are you currently SEXUALLY ACTIVE? YES NO
 If YES, what do you use for BIRTH CONTROL? _____
 (if you are on birth control pills please include the name of the pill)

Have you ever been diagnosed with any of the following SEXUALLY TRANSMITTED DISEASES? YES NO
 HERPES – HIV/AIDS – SYPHILIS – CHLAMYDIA – GONORRHEA (please circle)

PAST SURGICAL HISTORY:

Please list all of your prior SURGERIES (include common surgeries such as c-sections and cosmetic surgery):

Surgery	Year	Surgery	Year
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

MEDICATIONS:

Please list all PRESCRIBED MEDICATIONS that you take on a regular basis:

Medication	Dose	Medication	Dose
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

Please list all OVER-THE-COUNTER MEDICATIONS, SUPPLEMENTS, and VITAMINS you take on a regular basis:

1. _____	3. _____
2. _____	4. _____

ALLERGIES:

Please list all ALLERGIES TO MEDICATIONS:

	Medication	Reaction (rash, shortness of breath, etc)
1.	_____	_____
2.	_____	_____
3.	_____	_____

Please list any severe FOOD or ENVIRONMENTAL ALLERGIES you have _____

Are you allergic to LATEX? YES NO

FAMILY HISTORY:

Do you have a FAMILY HISTORY of any of the following problems?

M=mother F=father S=sister B=brother

MGM=maternal grandmother MGF=maternal grandfather PGM=paternal grandmother PGF=paternal grandfather

1. High blood pressure	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
2. Diabetes	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
3. Heart disease	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
4. Breast cancer	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
5. Ovarian cancer	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
6. Colon cancer	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
7. Thyroid disorder	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
8. Osteoporosis	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
9. Blood clotting disorder	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
10. Deep venous thrombosis (DVT – blood clot deep in leg)	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
11. Autoimmune disorders (such as lupus, rheumatoid arthritis, etc.)	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
12. Other _____										

MENSTRUAL HISTORY:

At what age did you START YOUR PERIODS? _____

If you are still having periods:

- When was your LAST MENSTRUAL PERIOD? _____
- Are your periods REGULAR or IRREGULAR?
- How many DAYS are there BETWEEN your cycles? _____
- How many DAYS do your periods LAST? _____
- Are your periods – LIGHT – MODERATE – HEAVY - CLOTS?
- Do you frequently SPOT between periods? YES NO
- Describe your CRAMPS: None Mild Moderate Severe

SOCIAL HISTORY:

Do you drink ALCOHOL? Rarely Occasionally Daily Never

Do you smoke CIGARETTES? Occasionally Daily Never Quit

Do you use ILLICIT SUBSTANCES? YES NO

Are you – MARRIED – SINGLE – WIDOWED – DIVORCED – SEPARATED?

Do you EXERCISE? Regularly Occasionally Never

Are you EMPLOYED outside the home? YES NO

If YES, what type of work do you do (if you are a student please include this information as well)

Do you have any issues with DOMESTIC VIOLENCE? YES NO

REPRODUCTIVE HISTORY:

How many TIMES have you been pregnant? _____

How many LIVING CHILDREN do you have? _____

Have you delivered any children PREMATURELY (before 37 weeks)? YES NO

If YES, how many? _____

Have you had any MISCARRIAGES? YES NO

If YES, how many? _____

Have you had any ELECTIVE ABORTIONS? YES NO

If YES, how many? _____

REVIEW OF SYSTEMS:

Please circle any SIGNIFICANT SYMPTOMS you currently experience:

NONE

- CONSTITUTIONAL: weight gain – weight loss – fatigue – loss of appetite – fevers – chills – other _____
- EYES: blurred vision – eye pain – discharge from eye – other _____
- HEAD & NECK: severe headaches – sore throat – nasal discharge – nose bleeds – decreased hearing – lightheadedness – other _____
- BREAST: lumps – tenderness – nipple discharge – other _____
- CARDIOVASCULAR: chest pain – irregular heart beat – fainting spells – other _____
- RESPIRATORY: shortness of breath – cough – wheezing – other _____
- GASTROINTESTINAL: nausea – vomiting – diarrhea – constipation – heartburn – abdominal pain – blood in stools – incontinence of stools – hemorrhoids – other _____
- GENITOURINARY: urinary frequency – pain with urination – blood in urine – urinary incontinence – difficulty urinating – vaginal discharge – pain with intercourse – bleeding with intercourse – significant PMS – other _____
- SKIN: rash – itching – acne – abnormal hair growth – other _____
- NEURO: headaches – weakness – numbness – other _____
- MUSCULOSKELETAL: joint pain – joint swelling – muscle weakness – muscle pain – other _____
- ENDOCRINE: increased thirst – increased urination – hair loss – heat intolerance – cold intolerance – other _____
- PSYCHIATRIC: anxiety – depression – confusion – other _____
- HEMATOLOGIC: easy bruising – easy bleeding – lymph node enlargement – other _____
- ALLERGIC: sinus allergies – skin allergies – other _____

I have filled out this form completely and to the best of my ability.

Signature _____ Date _____

Women's Medical Associates of Nashville

New Patient OB Form

Name _____ Age _____ Date of Birth _____ Date _____

PAST MEDICAL HISTORY:

Please list your past and current MAJOR MEDICAL ILLNESSES: NONE _____

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

When was your last PAP SMEAR? _____

Do you have any history of ABNORMAL PAP SMEARS? YES NO

Have you ever been diagnosed with any of the following SEXUALLY TRANSMITTED DISEASES? YES NO
 HERPES – HIV/AIDS – SYPHILIS – CHLAMYDIA – GONORRHEA (please circle)

PAST SURGICAL HISTORY:

Please list all of your prior SURGERIES (include common surgeries such as c-sections and cosmetic surgery):

- | Surgery | Year | Surgery | Year |
|----------|-------|----------|-------|
| 1. _____ | _____ | 5. _____ | _____ |
| 2. _____ | _____ | 6. _____ | _____ |
| 3. _____ | _____ | 7. _____ | _____ |
| 4. _____ | _____ | 8. _____ | _____ |

MEDICATIONS:

Please list all PRESCRIBED MEDICATIONS that you take on a regular basis, including any you discontinued for the pregnancy:

- | Medication | Dose | Medication | Dose |
|------------|-------|------------|-------|
| 1. _____ | _____ | 5. _____ | _____ |
| 2. _____ | _____ | 6. _____ | _____ |
| 3. _____ | _____ | 7. _____ | _____ |
| 4. _____ | _____ | 8. _____ | _____ |

Please list all OVER-THE-COUNTER MEDICATIONS, SUPPLEMENTS, and VITAMINS (including prenats) that you take on a regular basis, including any you discontinued for the pregnancy:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

ALLERGIES:

Please list all ALLERGIES TO MEDICATIONS:

- | Medication | Reaction (rash, shortness of breath, etc) |
|------------|---|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |

Please list any severe FOOD or ENVIRONMENTAL ALLERGIES you have: _____

Are you allergic to LATEX? YES NO

FAMILY HISTORY:

Do you have a FAMILY HISTORY of any of the following problems?

M=mother F=father S=sister B=brother

MGM=maternal grandmother MGF=maternal grandfather PGM=paternal grandmother PGF=paternal grandfather

- | | | | | | | | | | | |
|------------------------|-----|----|---|---|---|---|-----|-----|-----|-----|
| 1. High blood pressure | YES | NO | M | F | S | B | MGM | MGF | PGM | PGF |
| 2. Diabetes | YES | NO | M | F | S | B | MGM | MGF | PGM | PGF |

3. Heart disease	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
4. Breast cancer	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
5. Ovarian cancer	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
6. Colon cancer	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
7. Thyroid disorder	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
8. Osteoporosis	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
9. Blood clotting disorder	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
10. Deep venous thrombosis (DVT – blood clot deep in leg)	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
11. Autoimmune disorders (such as lupus, rheumatoid arthritis, etc.)	YES	NO	M	F	S	B	MGM	MGF	PGM	PGF
12. Other _____										

MENSTRUAL HISTORY:

At what age did you START YOUR PERIODS? _____

When was your LAST MENSTRUAL PERIOD? _____

Describe your periods before your pregnancy:

- Were your periods REGULAR or IRREGULAR?
- How many DAYS were there BETWEEN your cycles? _____
- How many DAYS did your did your periods LAST? _____
- Were your periods – LIGHT – MODERATE – HEAVY – CLOTS?
- Did you frequently SPOT between periods? YES NO
- Describe your CRAMPS: None Mild Moderate Severe

SOCIAL HISTORY:

Before your pregnancy did you drink ALCOHOL? Rarely Occasionally Daily Never

Do you smoke CIGARETTES? Occasionally Daily Never Quit

Do you use any ILLICIT DRUGS? YES NO

Are you – MARRIED – SINGLE – WIDOWED – DIVORCED – SEPARATED?

Do you EXERCISE? Regularly Occasionally Never

Are you EMPLOYED outside the home? YES NO

If YES, what type of work do you do (if you are a student please include this information as well)?

What is the name of the FATHER of your baby? _____

What is his OCCUPATION? _____

Do you have any issues with DOMESTIC VIOLENCE? YES NO

Do you wear a SEAT BELT in the car? YES NO

REPRODUCTIVE HISTORY:

How many TIMES have you been pregnant? _____

How many LIVING CHILDREN do you have? _____

Have you delivered any children PREMATURELY (before 37 weeks)? YES NO

If YES, how many? _____

Have you had any MISCARRIAGES? YES NO

If YES, how many? _____

Have you had any ELECTIVE ABORTIONS? YES NO

If YES, how many? _____

REVIEW OF SYSTEMS:

Please circle any SIGNIFICANT SYMPTOMS you currently experience:

NONE

- CONSTITUTIONAL: weight gain – weight loss – fatigue – loss of appetite – fevers – chills – other _____
- EYES: blurred vision – eye pain – discharge from eye – other _____
- HEAD & NECK: severe headaches – sore throat – nasal discharge – nose bleeds – decreased hearing – lightheadedness – other _____
- BREAST: lumps – tenderness – nipple discharge – other _____
- CARDIOVASCULAR: chest pain – irregular heart beat – fainting spells – other _____
- RESPIRATORY: shortness of breath – cough – wheezing – other _____
- GASTROINTESTINAL: nausea – vomiting – diarrhea – constipation – heartburn – abdominal pain – blood in stools – incontinence of stools – hemorrhoids – other _____
- GENITOURINARY: urinary frequency – pain with urination – blood in urine – urinary incontinence – difficulty urinating – vaginal discharge – pain with intercourse – bleeding with intercourse – significant PMS – other _____
- SKIN: rash – itching – acne – abnormal hair growth – other _____
- NEURO: headaches – weakness – numbness – other _____
- MUSCULOSKELETAL: joint pain – joint swelling – muscle weakness – muscle pain – other _____
- ENDOCRINE: increased thirst – increased urination – hair loss – heat intolerance – cold intolerance – other _____
- PSYCHIATRIC: anxiety – depression – confusion – other _____
- HEMATOLOGIC: easy bruising – easy bleeding – lymph node enlargement – other _____
- ALLERGIC: sinus allergies – skin allergies – other _____

GENETIC SCREENING:

Do YOU or the FATHER of your baby, or anyone in YOUR FAMILY, on the baby’s FATHER’S FAMILY have the following?

- | | | |
|--|-----|----|
| • Thalassemia | YES | NO |
| • Italian, Greek, Mediterranean, or Asian background | YES | NO |
| • Neural tube defect (meningomyelocele, spina bifida, anencephaly) | YES | NO |
| • Congenital heart defect | YES | NO |
| • Down syndrome | YES | NO |
| • Tay Sachs disease | YES | NO |
| • Eastern European Jewish or French Canadian background | YES | NO |
| • Canavan disease | YES | NO |
| • Sickle cell disease or trait | YES | NO |
| • Hemophilia or other blood disorder | YES | NO |
| • Muscular dystrophy | YES | NO |
| • Cystic fibrosis | YES | NO |
| • Huntington’s chorea | YES | NO |
| • Mental retardation | YES | NO |
| o If YES, was the person tested for Fragile X? | YES | NO |
| • Other inherited genetic or chromosomal disorder? | YES | NO |
| • Maternal metabolic disorder (diabetes, PKU) | YES | NO |

Have YOU or the FATHER of your baby had a CHILD with a BIRTH DEFECT not listed above?

YES NO

Do YOU or the FATHER of your baby have a BIRTH DEFECT?

YES NO

Do you a history of RECURRENT PREGNANCY LOSS or a STILLBIRTH?

YES NO

Have you taken any MEDICATIONS since your last menstrual period other than prenatal vitamins (including vitamins, supplements, over-the-counter-meds, drugs, and alcohol)?

YES NO

If YES, please list _____

Have you had any other GENETIC or ENVIRONMENTAL EXPOSURES to discuss?

YES NO

INFECTION HISTORY:

Do you live with someone with TB or who has had recent TB EXPOSURE?

YES NO

Do you or your partner have GENITAL HERPES?

YES NO

Have you had a RASH or VIRAL ILLNESS since your last menstrual period?

YES NO

Have you had CHICKEN POX in the past?

YES NO

If NO, have you had the CHICKEN POX VACCINE?

YES NO

Do you have any CATS at home?

YES NO

Do you have any CLOSE CONTACT WITH CHILDREN other than your own on a regular basis?

YES NO

I have filled out this form completely and to the best of my ability.

Signature _____ Date _____

Women's Medical Associates of Nashville

Established Patient OB Form

Name _____ Age _____ Date of Birth _____ Date _____

PAST MEDICAL HISTORY:

Since your last visit have you been diagnosed with any new HEALTH PROBLEMS? YES NO
 If YES, please describe _____

PAST SURGICAL HISTORY:

Have you had any recent SURGERIES? YES NO
 If YES, please describe _____

MEDICATIONS:

Please list all PRESCRIBED MEDICATIONS that you take on a regular basis, including any you discontinued for the pregnancy:

	Medication	Dose		Medication	Dose
1.	_____	_____	5.	_____	_____
2.	_____	_____	6.	_____	_____
3.	_____	_____	7.	_____	_____
4.	_____	_____	8.	_____	_____

Please list all OVER-THE-COUNTER MEDICATIONS, SUPPLEMENTS, and VITAMINS (including prenatals) that you take on a regular basis, including any you discontinued for the pregnancy:

1. _____	3. _____
2. _____	4. _____

ALLERGIES:

Have you developed any new ALLERGIES TO MEDICATIONS? YES NO
 If YES, list name of drug and reaction _____

FAMILY HISTORY:

Have there been any CHANGES in your FAMILY HISTORY? YES NO
 If YES, please note changes:

M=mother F=father S=sister B=brother

MGM=maternal grandmother MGF=maternal grandfather PGM=paternal grandmother PGF=paternal grandfather

- | | |
|---|-------------------------|
| 1. High blood pressure | M F S B MGM MGF PGM PGF |
| 2. Diabetes | M F S B MGM MGF PGM PGF |
| 3. Heart disease | M F S B MGM MGF PGM PGF |
| 4. Breast cancer | M F S B MGM MGF PGM PGF |
| 5. Ovarian cancer | M F S B MGM MGF PGM PGF |
| 6. Colon cancer | M F S B MGM MGF PGM PGF |
| 7. Thyroid disorder | M F S B MGM MGF PGM PGF |
| 8. Osteoporosis | M F S B MGM MGF PGM PGF |
| 9. Blood clotting disorder | M F S B MGM MGF PGM PGF |
| 10. Deep venous thrombosis
(blood clot deep in leg) | M F S B MGM MGF PGM PGF |
| 11. Autoimmune disorder
(such as lupus, rheumatoid arthritis, etc) | M F S B MGM MGF PGM PGF |
| 12. Other _____ | |

MENSTRUAL HISTORY:

Describe your periods before your pregnancy:

- When was your LAST MENSTRUAL PERIOD? _____
- Were your periods REGULAR or IIRREGULAR?
- How many DAYS were there BETWEEN your cycles? _____
- How many DAYS did your did your periods LAST? _____
- Were your periods – LIGHT – MODERATE – HEAVY – CLOTS?
- Did you frequently SPOT between periods? YES NO
- Describe your CRAMPS: None Mild Moderate Severe

SOCIAL HISTORY:

Before your pregnancy did you drink ALCOHOL? Rarely Occasionally Daily Never Quit
 Do you smoke CIGARETTES? Occasionally Daily Never Quit
 Do you use any ILLICIT DRUGS? YES NO
 Are you - MARRIED – SINGLE – WIDOWED – DIVORCED – SEPARATED?
 Do you EXERCISE? Regularly Occasionally Never
 Are you EMPLOYED outside the home? YES NO

If YES, what typed of work do you do (if you are a student please include this information as well)?

What is the name of the FATHER of your baby? _____

What is his OCCUPATION? _____

Do you have any issues with DOMESTIC VIOLENCE? YES NO

Do you wear a SEAT BELT in the car? YES NO

REVIEW OF SYSTEMS:

Please circle any SIGNIFICANT SYMPTOMS you currently experience:

NONE

- CONSTITUTIONAL: weight gain – weight loss – fatigue – loss of appetite – fevers – chills – other _____
- EYES: blurred vision – eye pain – discharge from eye – other _____
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- RESPIRATORY: shortness of breath – cough – wheezing – other _____
- GASTROINTESTINAL: nausea – vomiting – diarrhea – constipation – heartburn – abdominal pain – blood in stools – incontinence of stools – hemorrhoids – other _____
- GENITOURINARY: urinary frequency – pain with urination – blood in urine – urinary incontinence – difficulty urinating – vaginal discharge – pain with intercourse – bleeding with intercourse – significant PMS – other _____
- SKIN: rash – itching – acne – abnormal hair growth – other _____
- NEURO: headaches – weakness – numbness – other _____
- MUSCULOSKELETAL: joint pain – joint swelling – muscle weakness – muscle pain – other _____
- ENDOCRINE: increased thirst – increased urination – hair loss – heat intolerance – cold intolerance – other _____
- PSYCHIATRIC: anxiety – depression – confusion – other _____

- HEMATOLOGIC: easy bruising – easy bleeding – lymph node enlargement – other _____
- ALLERGIC: sinus allergies – skin allergies – other _____

GENETIC SCREENING:

Do YOU or the FATHER of your baby, or anyone in YOUR FAMILY, on the baby's FATHER'S FAMILY have the following?

- | | | |
|--|-----|----|
| • Thalassemia | YES | NO |
| • Italian, Greek, Mediterranean, or Asian background | YES | NO |
| • Neural tube defect (meningomyelocele, spina bifida, anencephaly) | YES | NO |
| • Congenital heart defect | YES | NO |
| • Down syndrome | YES | NO |
| • Tay Sachs disease | YES | NO |
| • Eastern European Jewish or French Canadian background | YES | NO |
| • Canavan disease | YES | NO |
| • Sickle cell disease or trait | YES | NO |
| • Hemophilia or other blood disorder | YES | NO |
| • Muscular dystrophy | YES | NO |
| • Cystic fibrosis | YES | NO |
| • Huntington's chorea | YES | NO |
| • Mental retardation | YES | NO |
| o If YES, was the person tested for Fragile X? | YES | NO |
| • Other inherited genetic or chromosomal disorder? | YES | NO |
| • Maternal metabolic disorder (diabetes, PKU) | YES | NO |

Have YOU or the FATHER of your baby had a CHILD with a BIRTH DEFECT not listed above?

YES NO

Do YOU or the FATHER of your baby have a BIRTH DEFECT?

YES NO

Do you a history of RECURRENT PREGNANCY LOSS or a STILLBIRTH?

YES NO

Have you taken any MEDICATIONS since your last menstrual period other than prenatal vitamins (including vitamins, supplements, over-the-counter-meds, drugs, and alcohol)?

YES NO

Have you had any other GENETIC or ENVIRONMENTAL EXPOSURES to discuss?

YES NO

INFECTION HISTORY:

Do you live with someone with TB or who has had recent TB EXPOSURE?

YES NO

Do you or your partner have GENITAL HERPES?

YES NO

Have you had a RASH or VIRAL ILLNESS since your last menstrual period?

YES NO

Have you had CHICKEN POX in the past?

YES NO

 If NO, have you had the CHICKEN POX VACCINE?

YES NO

Do you have any CATS at home?

YES NO

Do you have any CLOSE CONTACT WITH CHILDREN other than your own on a regular basis?

YES NO

I have filled out this form completely and to the best of my ability.

Signature _____ Date _____

Women's Medical Associates of Nashville

Annual Exam Update Form

Name _____ Age _____ Date of Birth _____ Date _____

PAST MEDICAL HISTORY:

Since your last visit have you been diagnosed with any new HEALTH PROBLEMS? YES NO
 If YES, please describe _____

PAST SURGICAL HISTORY:

Have you had any recent SURGERY? YES NO
 If YES, please describe _____

MEDICATIONS:

Please list all of your PRESCRIBED MEDICATIONS:

Medication	Dose	Medication	Dose
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

Please list all of the OVER-THE-COUNTER MEDICATIONS, SUPPLEMENTS, and VITAMINS you take on a regular basis:

1. _____	3. _____
2. _____	4. _____

ALLERGIES:

Have you developed any new ALLERGIES TO MEDICATIONS? YES NO
 If YES, please give name of medication and reaction _____

FAMILY HISTORY:

Have there been any CHANGES in your FAMILY HISTORY? YES NO
 If YES, please note changes:

M=mother F=father S=sister B=brother

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- | | |
|---|-------------------------|
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| 5. Ovarian cancer | M F S B MGM MGF PGM PGF |
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| 7. Thyroid disorder | M F S B MGM MGF PGM PGF |
| 8. Osteoporosis | M F S B MGM MGF PGM PGF |
| 9. Blood clotting disorder | M F S B MGM MGF PGM PGF |
| 10. Deep venous thrombosis
(blood clot deep in leg) | M F S B MGM MGF PGM PGF |
| 11. Autoimmune disorder
(such as lupus, rheumatoid arthritis, etc) | M F S B MGM MGF PGM PGF |
| 12. Other _____ | |

MENSTRUAL HISTORY:

If you are still having periods:

- When was your LAST MENSTRUAL PERIOD? _____
- Are your periods REGULAR or IRREGULAR?
- How many DAYS are there BETWEEN your cycles? _____
- How many DAYS do your periods last? _____
- Are your periods - LIGHT – MODERATE – HEAVY - CLOTS?
- Do you frequently SPOT between periods? YES NO
- Describe your CRAMPS: None Mild Moderate Severe

If you are POST-MEOPAUSAL do you have any significant MENOPAUSAL SYMPTOMS? YES NO
HOT FLASHES NIGHT SWEATS VAGINAL DRYNESS OTHER _____

Are you currently SEXUALLY ACTIVE? YES NO
If YES, what do you use to PREVENT PREGNANCY? _____
Do you need to CHANGE your BIRTH CONTROL METHOD? YES NO

SOCIAL HISTORY:

Do you drink ALCOHOL? Rarely Occasionally Daily Never
Do you smoke CIGARETTES? Occasionally Daily Never Quit
Do you use any ILLICIT SUBSTANCES? YES NO
Are you – MARRIED – SINGLE – WIDOWED – DIVORCED – SEPARATED?
Do you EXERCISE? Regularly Occasionally Never
Are you EMPLOYED outside the home? YES NO

If YES, what type of work do you do (if you are a student please include this information as well)?

Do you have any issues with DOMESTIC VIOLENCE? YES NO

REVIEW OF SYSTEMS:

Please circle any SIGNIFICANT SYMPTOMS you currently experience: **NONE**

- CONSTITUTIONAL: weight gain – weight loss – fatigue – loss of appetite – fevers – chills – other _____
- EYES: blurred vision – eye pain – discharge from eye – other _____
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- HEMATOLOGIC: easy bruising – easy bleeding – lymph node enlargement – other _____
- ALLERGIC: sinus allergies – skin allergies – other _____

I have filled out this form completely and to the best of my ability.

Signature: _____ Date: _____