OB/GYN CENTRE OF EXCELLENCE

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Date: ______________________ **Birthdate:** ______________ **Age:** ______

Name: ____
(Last) **(First)** **(MI)**

Allergies: ____

What is the reason for your visit today? ☐ Wellness Exam ☐ Other______________________

____

Primary Care Doctor______________________________

SURGERIES AND MEDICAL ILLNESSES______________________________

____

CURRENT MEDICATIONS AND DOSAGE______________________________

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Female History
Date of Last Menstrual Period____________ Type of Birth Control____________

Are You Currently Sexually Active? ________ Have you had a hysterectomy? ________

Date of Your Last Pap Smear________ Mammogram________ Bone Density________ Colonoscopy________

Family Medical History (Mother, Father, Sisters, Brothers, Grandparents)
☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Kidney Disease ☐ Osteoporosis

☐ Breast Cancer ☐ Uterine Cancer ☐ Ovarian Cancer ☐ Other Cancers______________________

Social History (Please specify amount)
☐ Tobacco____________ ☐ Alcohol____________ ☐ Illicit Drug Use____________

Review of Systems (Please Check All of the Following That Apply to You):

General Health
☐ Tired ☐ Loss of Appetite / Weight Loss ☐ Depressed ☐ Headaches ☐ Fever / Chills ☐ Cough

☐ Difficulty with Sleep

Heart
☐ Chest Pain / Weakness ☐ Rapid / Irregular Beat ☐ Dizzy / Fainting Spells

Gastrointestinal
☐ Constipation / Diarrhea ☐ Pain ☐ Nausea & Vomiting ☐ Heartburn ☐ Rectal Bleeding

Urinary
☐ Frequency / Urgency ☐ Leak Urine ☐ Painful Urination ☐ Blood in Urine

Gynecology
☐ Hot Flashes ☐ History of Abnormal Pap Smears ☐ Vaginal Discharge ☐ Heavy Periods ☐ Cramps with Periods

THE FOLLOWING WILL BE COMPLETED BY THE NURSE
Physical Exam

Height__________ **Weight**__________ **BP**__________ **Pulse**__________ **Resp.**__________