

Ob/Gyn Centre of Excellence

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Date: _____

Name: _____
(Last) (First) (Middle Initial)

Birthdate: _____ Age: _____

Referring Doctor: _____

What is the reason for your visit today? _____

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

General Health

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Tired | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Difficulty with Sleep | <input type="checkbox"/> Fever / Chills |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Hard of Hearing |

Heart

- | | | |
|---|---|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Dizzy or Fainting Spells | <input type="checkbox"/> Rapid Heart Beat | <input type="checkbox"/> Weakness in Arms / Legs |

Gastrointestinal

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Gas | <input type="checkbox"/> Nausea & Vomiting | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Heartburn | |

Urinary

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Frequency | <input type="checkbox"/> Burning | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Urgency | <input type="checkbox"/> Urination after Bed (Number of times _____) | |
| <input type="checkbox"/> Leak Urine | | |

Past Family Medical History (Mother, Father, Sisters, Brothers, Grandparents)

- | | | |
|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Cancer (What kind?) _____ | | |

Your Past Medical History

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sexually Transmitted Infections |
| <input type="checkbox"/> Other: _____ | | |

List All Surgeries (Including the Year):

Medication Allergies: _____

Your Past Medical History (Continued)

List All Medication That You are Currently Taking

Any Previous Blood Transfusions _____

Social History

Tobacco

Alcohol

Illicit Drug Use

Female History

Date of Last Menstrual Period _____

Age at First Menstrual Period _____

Number of Pregnancies _____

Number of Live Births _____

Weight of Largest Baby _____

Pregnancy Complications _____

Type of Birth Control _____

Are You Currently Sexually Active? _____

Gynecologic Surgeries (Check all that apply)

Tubal Ligation

Cesarean Section

Laparoscopy

D&C

Hysterectomy

Removal of Ovaries

Check All That Apply

Hot Flashes

Painful Intercourse

Heavy Menstrual Flow

Cramps with Periods

Vaginal Discharge

Leaking Urine

Urinary Frequency

Painful Urination

Infertility

History of Abnormal Pap Smears

Last Pap Smear _____

Last Mammogram _____

Last Bone Density Test _____

Physical Exam

Height _____ Weight _____ BP _____ Pulse _____ Resp. _____