Madonna OB/GYN

OFFICE USE ONLY		
RHIO	YES	NO
SURESCRIPTS	YES	NO

Appointment Date: _____

Name_____ Age_____ DOB_____

Preferred Pharmacy _____ Location _____

What is the reason for your visit? _____ (Annual exam) (Other) _____

Current medication and dosage _____

_____

_____

Medication Allergies _____ Do you have a LATEX Allergy? ____ (yes) ____ (no)

Date of last: PAP Smear_____ Tetanus Shot _____ Mammogram_____ Bone Density_____

Colonoscopy_____ Cholesterol Check_____ HPV Vaccine (Gardasil) _____

Pregnancy History: # of pregnancies _____ # of deliveries _____ # of living children _____

# of miscarriages _____ # of terminations _____ # of ectopic _____

❑ I have updated my medical history through the patient portal within the last year. **INTITAL AND DATE _____**

Please tell us about YOUR gynecological history.

When was the first day of your last menstrual period? _____ Number of days between cycles? _____

Age of first period _____ Are cycles regular? ___ (yes) ___ (no)

Please check if YOU are being treated or have been treated for any of the following: ❑ NONE

❑ SAME AS PREV. YEAR	INTITAL AND DATE _____	❑ SAME AS PREV. YEAR	INTITAL AND DATE _____
☐ Herpes	☐ Gonorrhea	☐ Chlamydia	☐ Genital Warts
☐ Endometriosis	☐ Pelvic Pain	☐ Ovarian Cysts	☐ Polycystic Ovaries
☐ Infertility	☐ Ovarian Cancer	☐ Uterine Cancer	☐ Heavy Periods
☐ Colposcopy	☐ LEEP	☐ Cryo (freezing)	☐ Other _____
☐	☐	☐	☐

Please check if YOU are being treated or have been treated for any of the following: ❑ NONE

❑ SAME AS PREV. YEAR	INTITAL AND DATE _____	❑ SAME AS PREV. YEAR	INTITAL AND DATE _____
☐ Anxiety	☐ Colon Cancer	☐ Heart Disease	☐ Osteoporosis/Osteopenia
☐ Arthritis	☐ COPD	☐ High Blood Pressure	☐ Reflux/GERD
☐ Asthma	☐ Depression	☐ High Cholesterol	☐ Seizures
☐ Blood Clots	☐ Diabetes	☐ Irritable Bowel	☐ Stroke
☐ Breast Cancer	☐ Diverticulitis	☐ Migraines	☐ Thyroid Disease
☐ Other_____		☐	

Please check if YOU have had any of these surgeries/treatments, including dates ❑ NONE

❑ SAME AS PREV. YEAR	INTITAL AND DATE _____	❑ SAME AS PREV. YEAR	INTITAL AND DATE _____
☐ Appendectomy	☐ Heart Surgery	☐ C-Section	☐ Hysterectomy
☐ Gallbladder	☐ Back/Neck	☐ D&C	☐ Tubal Ligation
☐ Bowel	☐ Breast	☐ Tonsillectomy	☐ Ovarian
☐ Uterine Ablation	☐	☐	☐

Name: _____

Please check if anyone if your immediate family (parents, siblings) has ever had the following. ❑ **NONE**

❑ **SAME AS PREV. YEAR INTITAL AND DATE** _____ ❑ **SAME AS PREV. YEAR INTITAL AND DATE** _____

☐ Breast Cancer	☐ Stroke	☐ Thyroid Disease	☐ Other _____
☐ Colon Cancer	☐ Heart Disease	☐ High Cholesterol	☐
☐ Ovarian Cancer	☐ Diabetes	☐ Osteoporosis/Osteopenia	
☐ Uterine Cancer	☐ Blood Clots	☐ High Blood Pressure	

Please CIRCLE if you are having a CURRENT problem with any of the following that you would like to discuss TODAY.

Sudden Weight Gain	**Sudden Weight Loss**	**Fatigue**	**Fever**	**Blurry Vision**	**Spots Before Eyes**	**Ear Ache**	**Ringing In Ears**
Bleeding Gums	**Mouth Sores**	**Sore Throat**	**Chest Pain**	**Palpitations**	**Irregular Heartbeat**	**Swelling Of Legs**	**Cough**
Shortness Of Breath	**Wheezing**	**Nausea**	**Vomiting**	**Abdominal Pain**	**Diarrhea**	**Constipation**	**Bloating**
Rectal Bleeding	**Hemorrhoids**	**Pain With Intercourse**	**Irregular Periods**	**Abnormal Vaginal Discharge**	**Vaginal Dryness**	**Pelvic Pain**	**Pain With Urination**
Incontinence	**Frequent Urination**	**Urgent Voiding**	**Blood In Urine**	**Swelling In Joints**	**Pain In Joints**	**Muscle Weakness**	**Skin Changes**
Dizziness	**Numbness**	**Seizures**	**Trouble Walking**	**Fainting**	**Headache**	**Depression**	**Anxiety**
Poor Sleep	**Impaired Memory**	**Mood Changes**	**Excessive Sweating**	**Excessive Thirst**	**Increased Urination**	**Hot Flashes**	**Night Sweats**
Dry Skin	**Easy Bleeding**	**Easy Bruising**	**Swollen Lymph Nodes**	**Seasonal Allergies**	**Food Allergies**	**Medication Allergies**	**Rash**
Changes In Moles	**Abnormal Lumps**						

Note: The discussion of any of the above issues may results in an additional fee for today's visit.

Occupation: _____

Marital Status: _____ with whom do you live _____

Are you sexually active? ___ (yes) ____ (no) Gender of partner(s): _____

Have you had unprotected sex with a partner who has traveled to an area with active Zika virus transmission ___ Yes ___ No

Contraception use (methods):_____

Do you preform self-breast exams? ____ (yes) _____ (no)

Do You?

Smoke	☐ No	☐ Yes _____packs/day?		☐ Quit	
Drink Alcohol	☐ No	☐ Yes, Occasionally		☐ Yes, Daily	
Use Marijuana	☐ No	☐ Yes, How Often:_____			
Use Street Drugs	☐ No	☐ Yes, List Drugs:_____			
Exercise	☐ No	☐ Yes, How Often:_____			

Do you take Calcium/Vitamin D?	☐ Yes	☐ No
Do you take a Multivitamin?	☐ Yes	☐ No
Do you use seat belts?	☐ Yes	☐ No
Do you have a Health Care Proxy	☐ Yes	☐ No

Are you being physically, sexually, or emotionally abused?	☐ Yes	☐ No
Do you want an HIV test?	☐ Yes	☐ No
Do you want any other STD testing?	☐ Yes	☐ No