



Madonna OB/GYN

OFFICE USE ONLY

RHIO	YES	NO
SURESCRIPTS	YES	NO

Appointment Date: _____

Name _____ Age _____ DOB _____

Phone Number (Home) _____ (Work) _____ (Cell) _____

E-Mail Address _____

Primary Care Doctor _____

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 _____

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)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Genital Warts |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Pelvic Pain | <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Polycystic Ovaries |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Uterine Cancer | <input type="checkbox"/> Heavy Periods |
| <input type="checkbox"/> Colposcopy | <input type="checkbox"/> LEEP | <input type="checkbox"/> Cryo (freezing) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> None of the above | | | |

Please check if YOU are being treated or have been treated for any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> COPD | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Reflux/GERD |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Other _____ | | <input type="checkbox"/> None of the above | |

Please check if YOU have had any of these surgeries/treatments, including dates.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> C-Section | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Back/Neck | <input type="checkbox"/> D&C | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Bowel | <input type="checkbox"/> Breast | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Ovarian |
| <input type="checkbox"/> Uterine Ablation | <input type="checkbox"/> None of the above | | |

Name: _____

Please check if ANYONE in your immediate family (parents, siblings) ever had the following.

<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> None
<input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoporosis/Osteopenia	
<input type="checkbox"/> Uterine Cancer	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> High Blood Pressure	

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

Note: The discussion of any of these issues may result in an additional fee for today's visit.

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						

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	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____ packs/day?	<input type="checkbox"/> Quit
Drink Alcohol	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Occasionally	<input type="checkbox"/> Yes, Daily
Use Marijuana	<input type="checkbox"/> No	<input type="checkbox"/> Yes, How Often: _____	
Use Street Drugs	<input type="checkbox"/> No	<input type="checkbox"/> Yes, List Drugs: _____	
Exercise	<input type="checkbox"/> No	<input type="checkbox"/> Yes, How Often: _____	

Do you take Calcium/Vitamin D?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you take a Multivitamin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use seat belts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a Health Care Proxy	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Are you being physically, sexually, or emotionally abused?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you want an HIV test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you want any other STD testing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No