Madonna
OBGYN

Appointment Date_____ **Name**_____ **Age**_____ **DOB**_____

Preferred Pharmacy_____Location_____

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

Medications and Dosages:_____

_____

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 __(yes) __(no)

Please tell us about YOUR gynecological history – check all that apply

First day of your last menstrual cycle?_____ Number of days between cycles?____ Age of first period____ Are cycles regular? ___(yes) ___(no)

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

☐ Herpes ☐ Gonorrhea ☐ Chlamydia ☐ Genital Warts ☐ Endometriosis ☐ Pelvic Pain

☐ Ovarian Cysts ☐ Polycystic Ovaries ☐ Infertility ☐ Ovarian Cancer ☐ Uterine Cancer ☐ Heavy Periods

☐ Colposcopy ☐ LEEP ☐ Cryo ☐ Other_____

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

☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Blood Clots ☐ COPD ☐ Breast Cancer

☐ Colon Cancer ☐ Depression ☐ Diabetes ☐ Diverticulitis ☐ Heart Disease ☐ High Blood Pressure

☐ High Cholesterol ☐ Irritable Bowels ☐ Migraines ☐ Reflux/GERD ☐ Osteoporosis ☐ Seizures

☐ Stroke ☐ Thyroid Disease ☐ Other_____

Circle if YOU have had any of these surgeries/treatments, and record the date of each surgery on the line provided.

Appendectomy_____ Gallbladder_____ Bowel_____ Uterine Ablation_____

Heart Surgery_____ Back/Neck_____ Breast_____ C-Section_____ D&C_____

Tonsillectomy_____ Hysterectomy_____ Tubal Ligation_____ Ovarian_____ Other_____

Please check if ANYONE in your immediate family has ever had the following:

☐ Breast Cancer ☐ Colon Cancer ☐ Ovarian Cancer ☐ Uterine Cancer ☐ Stroke ☐ Heart Disease

☐ Diabetes ☐ Blood Clots ☐ Thyroid Disease ☐ High Cholesterol ☐ High Blood Pressure

☐ Osteoporosis/Osteopenia ☐ Other_____

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	Palpitation	Irregular Heartbeat	Swelling of the 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 the 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
Abnormal Lumps	Changes in Moles						

Occupation_____ **Marital Status**:_____ **With whom do you live?**_____

Are you Sexually Active ? ___(yes) ___(no) ___(never) Gender of Partner(s):_____**What is your current gender(s)?** _____

What was your sex assignment at birth (ie birth certificate)?_____**What is/are your sexual orientation(s)?**_____

Contraception use (methods): _____**Do you perform self-breast exams?** ___(yes) ___(no)

Do you? Smoke ___(no) ___(yes) ___ daily? ___packs/day? ___quit?, Drink Alcohol ___(no) ___(yes),

Use Marijuana ___(no) ___(yes), How often?_____, Use Street Drugs ___(no) ___(yes) List Drugs:_____,

Exercise ___(no) ___(yes) How often:_____ Take Calcium/Vitamin D ___(no) ___(yes)

Take a Multivitamin ___(no) ___(yes) Use Seat Belts ___(no) ___(yes) Do you have a Health Care Proxy? ___(no) ___(yes)

Are you being physically, sexually, or emotionally abused? ___(no) ___(yes)

Do you want an HIV test, or any other STD testing? ___(no) ___(yes)