Lake Shore Obstetrics & Gynecology

Occupation: ______________ Primary Care Physician: _________________________

Referred by: __________________ Reason for visit today: ______________________

Have you ever had the following (circle all that apply):

Abnormal Mamm
Abnormal Pap
Anemia
Arthritis
Asthma/Emphysema
Blood transfusion
Cancer – type:
Clotting disorder
Depression
Diabetes (1 or 2)
DVT/PE
Endometriosis
Epilepsy
Fibroids- uterus
Frequent bladder infection
Genetic disorder
GERD
Headaches/Migraines
Heart Disease
High cholesterol
High blood pressure
HIV/AIDS
Irregular Vaginal Bleeding
Irritable Bowel/Colon
Kidney Disease
Liver Disorder
Lupus
Heart valve disorder
Osteopenia
Osteoporosis
Painful periods
Problem with anesthesia
STD :
Genital Herpes
Stroke
Thyroid–low / high
Vaginal infections
Other:

Your most recent	*Date*	*Result*	*Your most recent*	*Date*	*Result*
Pap smear			Colonoscopy		
HPV test			Cholesterol check		
Mammogram			Bone Density Scan		

List all surgeries and procedures

Surgery/Procedure	**Date**	**Surgery/Procedure**	**Date**

List all prescriptions, over-the-counter medications, and supplements taken regularly

Medication	**Dose**	**Frequency**	**Prescribing phyisician (or over the counter)**

List all food, drug, and environmental allergies and the reaction if exposed

Allergy	**Reaction**	**Allergy**	**Reaction**

FAMILY HISTORY If blood relative history unknown, proceed to page 2.

Has any blood relative had the following? Below, indicate "M" for maternal, "P" for paternal (i.e. Mother's mother = "MGM")

Problem	**Family Member**	**Age onset**	**Problem**	**Family Member**	**Age onset**
Cancer- breast			DVT/PE/clots		
Cancer- colon			Heart Disease		
Cancer- ovarian			High cholesterol		
Cancer- uterine			Hypertension		
Diabetes, type 1			Thyroid disorder		
Diabetes, type 2			Osteoporosis		

Gynecologic History

Age at first menstruation ______

Menopause? NO YES since age ______

First day of last menstrual period: ___/___/___

How often do you get your period? ______

How many days do your periods last? ______

Do you bleed/spot between periods? NO YES

Age at first intercourse: ______

How many total sexual partners ______

Current method of Birth Control: ________________

Have you ever been pregnant? NO YES how many ______

How many children have you had?______

Are they all living? NO YES

Have you had a miscarriage? NO YES how many ______

Have you had an abortion? NO YES how many ______

Have you had an ectopic pregnancy? NO YES

Do you have adopted children? NO YES how many ______

Sexual partners in the past year: ______

Obstetric History: Please list *all* deliveries, miscarriages, abortions

Date	# weeks	Length of labor (hrs)	Sex	Vaginal/C-section	Birth weight	Complications	Location

Marital Status: Single Engaged Married Divorced Widowed Domestic Partner

Do you currently smoke? NO : Never or Former (quit date: ______) YES: how much per day ______

Do you drink alcohol? NO YES: how much/often ________________

Do you use illegal drugs? NO YES: what, how often ________________

How much exercise do you do? NONE 1-2x/week 3-4x/week almost daily daily

Do you perform monthly Self Breast Exams? NO YES

Have you experienced sexual or physical abuse in the past or present? NO YES

Calcium intake per day: NONE # servings/day: _____ supplements: ______ mg per day

Please circle any symptoms you are currently having or have recently experienced:

Weight gain
Weight loss
Frequent headaches
Breast lumps
Nipple discharge
Breast tenderness/pain
Chest pain
Fainting
Shortness of breath with exercise

Diarrhea
Constipation
Blood in stools
Nausea/vomiting
Abdominal pain or bloating
New skin lesions
Changes in moles
Increased urinary frequency
Urinary urgency
Painful urination

Leaking urine
Vaginal discharge
Heavy periods
Irregular periods
Painful periods
Bleeding between periods
Hot flashes
Night sweats
Excess hair growth
Pain during intercourse

Frequent bruising
Bleeding easily
Joint pain
Joint swelling
Cough
Wheezing
Seasonal allergies
Anxiety
Depression
Insomnia