Lake Shore Obstetrics & Gynecology

Name:_____ Preferred Gender Pronoun _____ Age:____Date:_____

Occupation: _____Primary Care Physician: _____

Referred by: _____Reason for visit today:_____

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

Anxiety Abnormal Mammogram Abnormal Pap Anemia Arthritis Asthma/Emphysema Blood transfusion Cancer- type:_____ Clotting disorder	Depression Diabetes (1or 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 Polycystic Ovarian Syndrome (PCOS) 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

Pharmacy Name_____Address_____

Medication	Dose	Frequency	Prescribing Physician 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 unknown, proceed to page 2.**

Has any blood relative had the following? 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		
Cancer – Other			Thyroid Disorder		
Diabetes, Type 1			Osteoporosis		
Diabetes, Type 2			Other		

Complete both sides of form

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Name:_____

Gynecologic History

Age at first menstruation_____

Menopause? NO YES since age _____

First day of last menstrual period: _____j _____j _____

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 _____

Preference of sexual partner: □ Male □ Female □ Both

Have you ever had problems /treatment of infertility? NO YES

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: _____

If Applicable, Current Method of Birth Control_____

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

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

Marital Status: _____ Spouse/Partner Name:_____

Do you currently smoke/vape? NO: Never or Former: Quit Date _____YES: how much per day _____

Do you use smokeless tobacco? NO YES: which type _____

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

Do you use drugs recreationally? NO YES: what/how often _____

How often do you exercise? Never 1-2x/week 3-4x/week Almost daily Daily

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

Please check 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

Complete both sides of form