11-15 OB/GYN WORK SHEET: Please read this before your visit, and fill out as completely as possible. If there is a question that you do not understand, please make a check mark near the left margin. Every new patient is required to read and fill this out before being seen.

Name _____ Appointment date _____

Please spell your legal name as it appears on your picture ID and insurance card. **Initial and date each page**

Age _____ Date of birth _____ Place of birth _____

Primary Insurance _____Secondary Insurance _____

Primary MD: _____ Previous OB/GYN: _____

TOTAL number of all PREGNANCIES	# FULL TERM Delivery > 37weeks	# PRETERM Delivery <37 weeks	Abortion, Miscarriage, Ectopics Total loss less than 22 weeks	Number of LIVING BIOLOGICAL CHILDREN

CC/HPI: In a few words, can you please describe the nature of your visit, or your list of problems? Duration: how long: days, weeks, months, years? **Severity:** mild or minimal, moderate/worse, severe/worst **Quality:** can you describe it? What makes is better/worse?

LMP

EDD

EGA

__Annual Well Woman __Contraceptive __Problem __New __Established __MD referral: __ER/hospital follow-up: __ER facility/hospital name:

First day of last menstrual period/cycle?
LMP date: _____
__unknown
__greater than one month
__greater than one year
Age of first menses/cycle: how old?
_____
How often does your period/cycle come?
_____
How many days of flow in period/cycle?
_____
Was the last period/cycle normal?
_____
If no menses, why?
__hysterectomy
__uterine ablation
_____
If no menses, age at last menses:
_____
Last known pap smear date/result:
__if known, date (MM/DD/YEAR)
_____
__unknown
__never had a pap smear
__less than one year
__greater than one year
Abnormal pap history:
__none, no abnormal pap smears
__unknown
__past abnormal pap
__mild dysplasia, LGSIL
__moderate dysplasia, HGSIL
__severe dysplasia, HGSIL
__cervical cancer, invasive, or suspicious
__colposcopy
__cryotherapy (freezing)
__LEEP (loop electrocautery excision)
__cone biopsy, or cold knife cone biopsy
Risk of sexually transmitted infections:
__No history of sexual activity or contact in life, therefore no possible risk
__mutual monogamy, i.e. one mutual partner for life, therefore no possible risk
__not currently sexually active
__currently monogamous
__possible risk is unknown, or unsure
__definite risk, and testing is desired
Have you ever had a sexually transmitted disease/infection?
__yes
__no
If yes, list any STD/STIs you have had in your life:
__gonorrhea
__chlamydia
__trichomonas
__herpes type I (fever blister type)
__herpes type II (genital type)
__HIV (human immunodeficiency virus, or the AIDS virus)
__HPV (human papilloma virus)
__syphilis
__other:_____
Please indicate any STD test you desire:
__none, no STD testing requested
__gonorrhea, chlamydia, trichomonas
__HIV antibody
__Hepatitis B surface antibody
__Hepatitis C antibody
__Herpes type II antibody
__Syphilis screening
Last known mammogram date:
__never had a mammogram
__unknown
__less than one year
__greater than one year
__if known, MM/DD/YEAR:
_____
Where are your mammograms done?
__N/A
__McLeod Florence
__McLeod Darlington
__Carolina Pines
__Cheraw
__Bennettsville
__ImageCare
__Other, please list
_____
Other breast imaging: MRI: Thermogram:
_____

PHARMACY name and location, to transmit your prescription electronically. This will be the pharmacy on file that we use for your prescriptions:

Pharmacy name/address _____ City _____Tel # _____

Allergies to medications: Please **circle** or list below all allergic substances that apply to you:

__ No known drug allergies, that is, NDKA
__penicillin __erythromycin
__flagyl __sulfa

__I am not allergic to latex
__codeine __latex
__aspirin __peanut

Allergic reaction producing drug or other substance	Reaction

GYN reproductive history:

Sexual problems

__None
__sexually active, experiencing problems
__no desire for sex
__painful sex, other_____

Vaginal problems

__None
__vaginal irritation
__vaginal dryness
__vaginal itching
__vaginal odor
__vaginal area rash or lesions
__vaginal discharge
__vaginal bleeding
__vaginal pain

Pain

__None
__pelvic pain
__abdominal pain
__low back pain
__breast pain
__other pain:
_____

Birth control method

__None
__currently trying to get pregnant
__condoms
__sponge
__spermicide
__cervical cap
__diaphragm
__oral contraceptive pills
__contraceptive patch
__contraceptive implant in arm
__contraceptive vaginal insert (NuvaRing)
__contraceptive injection/shot (Depo)
__female sterilization, tubal ligation
__male sterilization, vasectomy
__infertility, other:
_____

Other GYN problems:
_____
_____
_____

TO ALL PATIENTS: please collect a urine sample before you go to the examination room, and empty your bladder.

PAST MEDICAL HISTORY: Please list ALL of your current and past personal medical problems, conditions, injuries, and hospitalization reasons.
Please check/list below ALL that apply to you personally, give the approximate year or age at diagnosis if known. This is your own medical history.
__ I am generally healthy, and I do not have, and have never had, any medical conditions, problems, injuries, hospitalizations, etc.

General: Illnesses/Infections
__Chicken pox, varicella
_____

Eyes
__Cataracts
__Glaucoma
_____

ENT (ear, nose, throat)
__Sinusitis
_____

Cardiovascular
__High blood pressure
__Heart disease
__Heart failure
__Deep vein blood clot
_____

Respiratory
__Asthma
__Bronchitis
__COPD (obstructive lung disease)
__sleep apnea (breathing stops)
__snoring
__pneumonia
_____

Gastrointestinal
__Celiac/gluten sensitivity
__ongoing constipation
__ongoing diarrhea
__gallbladder disease
__pancreatitis
__gastric reflux disorder
__anal/hemorrhoids disorder
__ongoing colon disorder
_____

Genito-urinary, Gynecology
__vaginitis
__pelvic inflammatory disease
__endometriosis
__uterine fibroids
__ovarian cyst
__polycystic ovarian syndrome
__fallopian tubal problems
__pelvic pain
__urinary tract infection
__urinary incontinence
__kidney infection
__kidney stones
__kidney disease
_____

Menopausal syndrome
__perimenopausal
__postmenopausal
__osteoporosis
_____

Integument/skin/breast
__acne
__eczema/atopic dermatitis
__fungal skin infection
__hidradenitis
__breast disease or cyst
__breast implants
__breast cancer
_____

Endocrine
__juvenile diabetes
__gestational diabetes
__pre-diabetes/syndrome X
__adult diabetes
__low hypo thyroid
__high hyper thyroid
_____

Musculoskeletal
__fibromyalgia
__low back pain
__joint pain
_____

Neurological
__migraine headache
__stroke
__seizure disorder
__Parkinson's
__Autistic disorder
__Insomnia, trouble sleeping
_____

Psychiatric
__anxiety
__depression
__mental illness
_____

Hematologic
__anemia
__sickle cell disease/trait
_____

Allergic/Immunologic
__arthritis
__autoimmune disease

Other, please list below:
_____
_____
_____

Surgical History:

__None, no surgery
__cesarean section
__diagnostic laparoscopy
__ectopic pregnancy
__exploratory abdominal
__gallbladder removal
__hysterectomy
__cervical LEEP (loop electrocautery excision) or cone biopsy
__ovarian cyst, ovary surgery
__tubal ligation (sterilization)
__hysteroscopy

Surgical complications?
Anesthesia complications?

Current medications: please list ALL medications you take including prescriptions, over the counter drugs, vitamins, supplements, others.
If you have a current list of medicines with you, we can copy it for you, or you may use the back of this paper.
__None. I do not take any medications, supplements or others. Do you take any of the following?
__Contraceptives
__Multivitamin
__Vitamin D3
__Omega 3 essential fatty acids/fish oils?
__Probiotics

Medication	Milligrams/strength	Frequency of dosage / how taken

Social history:
Legal marital status:
__Single __Married __Divorced
__Widowed
Ethnicity (for meaningful use):
__Mediterranean
__Caucasian
__African/black
__Latino/Hispanic
__Asian
_____
Significant other name:
_____
Ages of children:
_____
Living arrangements:
__live alone
__with family
__residential facility
__with husband or spouse
__with children
Substance use
__smoking/tobacco
__alcohol use
__recreational drugs of abuse including marijuana, cocaine, methamphetamine, oxycodone, barbiturates?
Addiction history
__any history of the above?
_____
Education
Grade/degree last completed
_____
Occupation/job title:
_____
Your infectious disease history:
__Exposure to TB, tuberculosis
__History or exposure to genital herpes
__History or exposure to HIV
__History or exposure to Hepatitis
__History of or exposure to an STD
Your immunization history:
Influenza, or flu vaccine
Varicella or chicken pox virus vaccine
Hepatitis A
Hepatitis B
Meningococcal
Pneumococcal
Gardasil or other HPV vaccine

Family history of specific diseases. Please indicate if you have **a family history** of one of the conditions below. (If not, list any others by using the list provided in the personal past medical history on the previous page).
Genetic screening/teratology history: Please check any of the following conditions in you and/or your genetically related family, i.e.:
__None of the following apply to me
__Abnormal hemoglobin
__Recurrent pregnancy loss
__Stillbirth, fetal loss
__Congenital heart defect
__Sickle cell disease or trait
__Ashkenazi Jewish ancestry
__Muscular dystrophy
__Cystic fibrosis
__Mental disability/retardation/autism
__Inherited chromosomal disorder
__Use of illicit drugs, prescription drugs or herbal medications since your last menstrual period: please make a list
_____
_____

Do you have any Family History of any of the following cancers?
__Breast CA
__Ovarian CA
__Endometrial or Uterine CA
__Other female organ CA
__Colon or rectal CA
__Prostate CA

Disease process	Mother's or Father's side	Relationship to you	Approximate age diagnosed

Mother's medical history, this applies to your biological or blood relative. If unknown, please check here__

Any disease or healthy?	Alive or deceased	Current age, or age at death	If deceased, cause of death, age?

Past pregnancies history (please list details of ALL your past pregnancies if this section applies): __ Not applicable, no pregnancies.
Full term birth(s) (37 weeks or greater): _____
Preterm birth(s) (less than 37 weeks): _____
Spontaneous miscarriage(s) (non-living, less than 500 grams, or less than 23 weeks): _____
Induced abortion(s)/ termination(s): _____
Abortion(s) at how many weeks: _____
Ectopic pregnancy(ies): _____
Living biological children: _____

Date/year	Weeks gestation	Birth weight	Delivery type	Complications / notes

NAME **DATE**

Review of systems form: Please check off each of the following symptoms based on your own symptom profile recently, **over the last 30 days**, or since your last visit. If your specific symptoms are not listed, please write in at the bottom of that system, or below.

Constitutional symptoms
__headache
__fever
__chills
__fatigue/malaise
__lightheadedness
__night sweats
__weakness

_____

Eyes
__blurred vison
__eye discharge
__eye problem
__eye redness

_____

ENT (Ears, Nose, Throat)
__nasal discharge
__difficulty swallowing
__sore throat
__hoarseness

_____

Cardiovascular (heart, vessels)
__chest pain
__palpitations
__irregular heart beat
__cold hands/feet
__swollen hands/feet
__black outs

_____

Respiratory (lungs)
__shortness of breath
__cough
__congestion
__wheezing
__snoring
__difficulty breathing

_____

Gastrointestinal (digestive)
__abdominal pain
__nausea
__vomiting
__diarrhea
__constipation
__appetite change
__indigestion
__belching
__excess gas
__hemorrhoids

_____

Genitourinary
__urinary frequency
__urinary urgency
__painful urination
__blood in urine
__incontinence
__flank/back pain
__urinating at night

_____

Gynecologic
__abnormal vaginal bleeding
__vaginal discharge
__vaginal irritation
__vaginal lesion
__vaginal odor
__vaginal pain
__uterine fibroids

_____

Musculoskeletal (muscles, joints, bones)
__low back pain
__stiffness
__weakness
__joint pain
__joint swelling

_____

Integument (skin/breast)
__breast lump
__breast discharge
__breast pain
__discoloration
__dryness
__itching
__hair changes
__nail changes
__moles
__pimples
__rashes
__redness

_____

Neurological (nervous system)
__memory loss
__migraine
__seizures
__twitching
__weakness
__dizziness
__numbness
__tremors

_____

Psychiatric
__depression
__obsessive thoughts
__irritability
__anxiety
__forgetfulness
__mood swings
__stress

_____

Endocrine (glands)
__extreme thirst
__increased urination
__increased appetite
__weight loss
__weight gain

_____

Menopausal
__hot flashes
__vaginal dryness
__night sweats
__insomnia
__irritability
__loss of sex drive
__painful sex

_____

Diet
__caffeine intake
__food intolerances
__gluten/wheat use
__dairy/milk use
__trans fatty acids
__sugar and corn syrup
__artificial sweeteners use
__fast food consumption
__farm raised/Atlantic fish
__tuna/swordfish
__packaged/processed foods

_____

Hematologic/Lymphatic
__anemia
__blood clotting problems
__bleeding tendencies
__easy bruisability
__infections
__bleeding gums

_____

Allergic/Immunologic
__allergies
__itchy, watery eyes
__nasal congestion
__hives
__antibiotic use
__swollen glands

_____

Healthy Lifestyle
__exercise
__stress relieving activities
__meditation or prayer
__dietary supplements
__use of vitamins
__5-9 servings of fruit/veg
__probiotics use
__supplemental Vit D
__sun exposure

_____

NAME **DATE**

OBGYN HISTORY QUESTIONNAIRE ANSWER SHEET (PLEASE READ OVER AND REFER TO THE INSTRUCTION SHEET BEFORE FILLING THIS OUT)

Chief complaint:_____

CC/HPI: _____

Age _____ Parity: G (total) _____ F(full term) _____ P (preterm) _____ A (abortion, miscarriage, ectopic) _____ L (living) _____

LMP _____

Last pap date_____ __unknown __greater than one year __greater than 2 years

Last pap result: __WNL, normal __ASCUS __ASC-H __LGSIL/LSIL __HGSIL/HSIL __HR HPV positive __HR HPV negative __Colpo

STD risk? yes _____ no _____ Do you want to be tested for STD's today? yes _____ no _____

Last MMG if over age 40 _____

Past medical _____

Have you had any personal history of breast, ovarian, or other female cancer? yes _____ no _____

Have you ever had a blood clot of the leg, lung, or brain? yes _____ no _____

Past surgical _____

Have you had a hysterectomy? yes _____ no _____ Do you still have a cervix? yes_____ no _____

Have you had any personal history of cervical disease, HPV, LEEP, colposcopy? yes _____ no _____

Pregnancy history _____

GYN history: age of first menses _____ flow number of days _____ cycle number of days _____ normal?

Medications: _____

Pharmacy: _____

Allergies: _____

Social: tobacco? yes _____ no _____ alcohol? Yes _____ no _____ drugs? yes _____ no _____

Marital status legally: Single _____ Married _____ Divorced _____ Widowed _____

Ethnicity: Mediterranean_____ Caucasian _____ African _____ Latino _____ Asian

Family history: Any cancer of the: Breast? yes _____ no _____ Ovary? yes _____ no _____ Uterus? yes _____ no _____

Is your mother alive? yes _____ no _____ age? _____ healthy? yes _____ no, health problem _____

Office use only below this line:

Ht	**Wt**	**BP**	

EXAM:

1)__ Constitutional
2)__ Genitourinary
3)__ Abdominal
4)__ Chest (Breasts)
5)__ Neck
6)__ Respiratory
7)__ Cardiovascular
8)__ Gastrointestinal
9)__ HEENT
10)__ Lymphatic
11)__ Neurologic
12)__ Psychiatric
13)__ Musculoskeletal
14)__ Extremities
15)__ Integumentary
16)__ Surgical Site

Abnormals: