

**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:

<p><b>First day of last menstrual period/cycle?</b>  <b>LMP date:</b> _____          ___ unknown          ___ greater than one month          ___ greater than one year  <b>Age of first menses/cycle: how old?</b>          _____  <b>How often does your period/cycle come?</b>          _____  <b>How many days of flow in period/cycle?</b>          _____  <b>Was the last period/cycle normal?</b>          _____  <b>If no menses, why?</b>          ___ hysterectomy          ___ uterine ablation          _____  <b>If no menses, age at last menses:</b>          _____  <b>Last known pap smear date/result:</b>          ___ if known, date (MM/DD/YEAR)          _____          ___ unknown          ___ never had a pap smear          ___ less than one year          ___ greater than one year  <b>Abnormal pap history:</b>          ___ none, no abnormal pap smears          ___ unknown          ___ past abnormal pap</p>	<p>___ 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  <b>Risk of sexually transmitted infections:</b>          ___ No history of sexual activity or contact in life, <u>therefore no possible risk</u>          ___ mutual monogamy, i.e. one mutual partner for life, <u>therefore no possible risk</u>          ___ not <u>currently</u> sexually active          ___ currently monogamous          ___ possible risk is unknown, or unsure          ___ definite risk, and testing is desired  <b>Have you ever had a sexually transmitted disease/infection?</b>          ___ yes          ___ no  <b>If yes, list any STD/STIs you have had in your life:</b>          ___ gonorrhea          ___ chlamydia          ___ trichomonas          ___ herpes type I (fever blister type)          ___ herpes type II (genital type)          ___ HIV (human immunodeficiency virus, or the AIDS virus)</p>	<p>___ HPV (human papilloma virus)          ___ syphilis          ___ other: _____  <b>Please indicate any STD test you desire:</b>          ___ none, no STD testing requested          ___ gonorrhea, chlamydia, trichomonas          ___ HIV antibody          ___ Hepatitis B surface antibody          ___ Hepatitis C antibody          ___ Herpes type II antibody          ___ Syphilis screening  <b>Last known mammogram date:</b>          ___ never had a mammogram          ___ unknown          ___ less than one year          ___ greater than one year          ___ if known, MM/DD/YEAR: _____  <b>Where are your mammograms done?</b>          ___ N/A          ___ McLeod Florence          ___ McLeod Darlington          ___ Carolina Pines          ___ Cheraw          ___ Bennettsville          ___ ImageCare          ___ Other, please list _____  <b>Other breast imaging: MRI: Thermogram:</b>          _____</p>
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**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, <b>NDKA</b> | ___ I am <b>not</b> allergic to latex |             |            |
| ___ penicillin                                    | ___ erythromycin                      | ___ codeine | ___ latex  |
| ___ flagyl  | ___ sulfa                             | ___ 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
- Vitamin D3
- Probiotics
- Multivitamin
- Omega 3 essential fatty acids/fish oils?

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 Full term birth(s) (37 weeks or details of ALL your past pregnancies greater):** \_\_\_\_\_  
 if this section applies):  Not applicable, no pregnancies. **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

- diarrhea
- constipation
- appetite change
- indigestion
- belching
- excess gas
- hemorrhoids

- hair changes
- nail changes
- moles
- pimples
- rashes
- redness

**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

**Eyes**

- blurred vision
- eye discharge
- eye problem
- eye redness

**Genitourinary**

- urinary frequency
- urinary urgency
- painful urination
- blood in urine
- incontinence
- flank/back pain
- urinating at night

**Neurological (nervous system)**

- memory loss
- migraine
- seizures
- twitching
- weakness
- dizziness
- numbness
- tremors

**Hematologic/Lymphatic**

- anemia
- blood clotting problems
- bleeding tendencies
- easy bruisability
- infections
- bleeding gums

**ENT (Ears, Nose, Throat)**

- nasal discharge
- difficulty swallowing
- sore throat
- hoarseness

**Gynecologic**

- abnormal vaginal bleeding
- vaginal discharge
- vaginal irritation
- vaginal lesion
- vaginal odor
- vaginal pain
- uterine fibroids

**Psychiatric**

- depression
- obsessive thoughts
- irritability
- anxiety
- forgetfulness
- mood swings
- stress

**Allergic/Immunologic**

- allergies
- itchy, watery eyes
- nasal congestion
- hives
- antibiotic use
- swollen glands

**Cardiovascular (heart, vessels)**

- chest pain
- palpitations
- irregular heart beat
- cold hands/feet
- swollen hands/feet
- black outs

**Musculoskeletal (muscles, joints, bones)**

- low back pain
- stiffness
- weakness
- joint pain
- joint swelling

**Endocrine (glands)**

- extreme thirst
- increased urination
- increased appetite
- weight loss
- weight gain

**Respiratory (lungs)**

- shortness of breath
- cough
- congestion
- wheezing
- snoring
- difficulty breathing

**Integument (skin/breast)**

- breast lump
- breast discharge
- breast pain
- discoloration
- dryness
- itching

**Menopausal**

- hot flashes
- vaginal dryness
- night sweats
- insomnia
- irritability
- loss of sex drive
- painful sex

**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

**Gastrointestinal (digestive)**

- abdominal pain
- nausea
- vomiting

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	
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**EXAM:**

- |                      |                        |                        |                      |
|----------------------|------------------------|------------------------|----------------------|
| 1)___ Constitutional | 4)___ Chest (Breasts)  | 9)___ HEENT            | 14)___ Extremities   |
| 2)___ Genitourinary  | 5)___ Neck             | 10)___ Lymphatic       | 15)___ Integumentary |
| 3)___ Abdominal      | 6)___ Respiratory      | 11)___ Neurologic      | 16)___ Surgical Site |
|                      | 7)___ Cardiovascular   | 12)___ Psychiatric     | <b>Abnormals:</b>    |
|                      | 8)___ Gastrointestinal | 13)___ Musculoskeletal |                      |