

FLOWER MOUND WOMEN'S CARE

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Obstetrics & Gynecology

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Name: _____ Date: _____ Age: _____
 Name of Primary Care Physician: _____

For what reason are you seeing the doctor? *if there is a question you do not feel comfortable answering, you can leave it blank and we will go over it in the visit if necessary.

- ❖ Is this a new problem?
- ❖ Please describe your problem including where it is, how severe it is, and how long it's lasted.

Current medications

(Including hormones, vitamins, herbs, nonprescription medications)

Drug name	Dosage	Who prescribed	Month / Year began taking
1			
2			
3			
4			
5			

Personal Past History of Illnesses

Major Illnesses	Yes (Date)	No	Major Illnesses	Yes (Date)	No
Asthma			Reflux / Hiatal Hernia / Ulcers		
Pneumonia / Lung disease			Depression / Anxiety		
Migraine Headaches			Anemia		
Kidney Infections / Stones			Blood Transfusions		
Tuberculosis			Seizures / Convulsions / Epilepsy		
HIV / AIDS			Bowel Problems		
Heart Attack / Problems			Glaucoma		
Diabetes			Cataracts		
High Blood Pressure			Arthritis / Joint / Back Problems		
Stroke			Broken Bones		
Rheumatic Fever			Hepatitis / Yellow Jaundice / Liver Disease		
Eating Disorders			Thyroid Disease		
Collagen Vascular Disease (Lupus)			Gallbladder Disease		
Chicken Pox			Headaches		
			Other		

Allergies (Medications or Foods)

Medication or Food	Reaction	Medication or Food	Reaction

Gynecologic History

First day of last menstrual period: ___ / ___ / ___	When was your last pap test?
Age period began:	What was the result?
Length of periods (number of days of bleeding):	Have you ever had an abnormal pap test?
Number of days between periods:	What treatments were taken? (cryo, freezing, LEEP, CONE)
Any recent changes in periods?	Have you ever been diagnosed with any STD's (HPV, HIV, genital warts, herpes, gonorrhea, Chlamydia, trichomonas, hepatitis, syphilis)?
Have you ever had sex?	Do you have a history of infertility?
Are you currently sexually active?	Have you ever taken or are you taking HRT (hormone replacement therapy)?
Sexual partners are: ___ men ___ women ___ both	Have you ever had any of the following, if so when was the last time?
Number of sexual partners (lifetime):	Mammogram
Present method of birth control:	Bone Mineral Density Test
Last prior methods of birth control:	Screening for Colon Cancer
History of Endometriosis?	(Occult blood test, sigmoidoscopy, colonoscopy)
History of Fibroids?	

Obstetric History

	Number		Number		Number
Pregnancies (total)		Miscarriages		Live Births	
Premature Births (<37 weeks)		Abortions		Living Children	

Pregnancies:

No	Date	Weeks Pregnant	Hours of Labor	Baby's Weight	Baby's Sex	Type of Delivery (vaginal / cesarean)	Type of anesthesia	Place of delivery	Complications
1									
2									
3									
4									
5									

Surgical History:

Operation	Date	Reason	Hospital

Hospitalizations (other than for surgery):

Reason	Date	Hospital

Family Medical History:

Mother: Living Deceased, cause _____ Age: _____
Father: Living Deceased, cause _____ Age: _____

Siblings: Number living: _____ Number deceased: _____ cause(s)/ages: _____

Children: Number living: _____ Number deceased: _____ cause(s)/ages: _____

Illnesses	Yes	Which Relative(s) and age of onset
Diabetes	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	
Blood clots in lungs or legs	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	
High cholesterol	<input type="checkbox"/>	
Osteoporosis (weak bones)	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	
HIV / AIDS	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	
Birth defects	<input type="checkbox"/>	
Drinking or Drug problems	<input type="checkbox"/>	
Breast Cancer	<input type="checkbox"/>	
Colon Cancer	<input type="checkbox"/>	
Uterine or Ovarian Cancer	<input type="checkbox"/>	
Mental illness / depression	<input type="checkbox"/>	
Alzheimer's Disease	<input type="checkbox"/>	
Other	<input type="checkbox"/>	

Social History

	yes	no		yes	no
Ever smoked? Current smoking: packs per day: _____ years: _____	<input type="checkbox"/>	<input type="checkbox"/>	Regular Exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol: Drinks per day _____ Drinks per week: _____	<input type="checkbox"/>	<input type="checkbox"/>	Health hazards at home or work?	<input type="checkbox"/>	<input type="checkbox"/>
Recreational Drug use	<input type="checkbox"/>	<input type="checkbox"/>	Have you been sexually abused, threatened, or hurt by anyone?	<input type="checkbox"/>	<input type="checkbox"/>
Seat Belt use	<input type="checkbox"/>	<input type="checkbox"/>			
Sexual Orientation: <input type="checkbox"/> heterosexual <input type="checkbox"/> homosexual <input type="checkbox"/> bisexual					
Marital Status: <input type="checkbox"/> married <input type="checkbox"/> living with partner <input type="checkbox"/> single <input type="checkbox"/> widowed <input type="checkbox"/> divorced					
Number of living children: _____					
School completed: <input type="checkbox"/> high school <input type="checkbox"/> some college / aa degree <input type="checkbox"/> college <input type="checkbox"/> graduate degree <input type="checkbox"/> other					
Current or most recent job: _____					
Travel outside the U.S.?					
Hometown: _____					

Review of *Current* Symptoms

(Check all that apply)

Constitutional		Female reproductive	
Weakness	<input type="checkbox"/>	Abnormal bleeding	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	Painful periods	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	Heavy periods	<input type="checkbox"/>
Fever	<input type="checkbox"/>	Premenstrual syndrome (PMS)	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	Painful intercourse	<input type="checkbox"/>
Change in height	<input type="checkbox"/>	Fibroids	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	Infertility	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	DES exposure	<input type="checkbox"/>
Eyes		Abnormal vaginal discharge	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	Frequent yeast infections	<input type="checkbox"/>
Spots before eyes	<input type="checkbox"/>	Pelvic pain	<input type="checkbox"/>
Vision changes	<input type="checkbox"/>	Musculoskeletal	
Glasses / Contacts	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>
Ears, Nose, Throat		Muscle or joint pain	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	Skin	
Ringing in ears	<input type="checkbox"/>	Rash	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	Dry skin	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	Moles	<input type="checkbox"/>
Mouth sores	<input type="checkbox"/>	Hives	<input type="checkbox"/>
Cardiovascular		Lumps	<input type="checkbox"/>
Painful breathing	<input type="checkbox"/>	Breasts	
Chest pain or pressure	<input type="checkbox"/>	Pain in breasts	<input type="checkbox"/>
Difficulty breathing on exertion	<input type="checkbox"/>	Nipple discharge	<input type="checkbox"/>
Swelling of legs	<input type="checkbox"/>	Lumps	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	Neurologic	
Varicose veins	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Respiratory		Tingling / numbness	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	Trouble walking	<input type="checkbox"/>
Spitting up blood	<input type="checkbox"/>	Severe memory problems	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	Frequent or severe headaches	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	Difficulty sleeping	<input type="checkbox"/>
Gastrointestinal		Psychiatric	
Nausea	<input type="checkbox"/>	Depression or frequent crying	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	Severe anxiety	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	High stress level	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	Sleep disturbances	<input type="checkbox"/>
Frequent diarrhea	<input type="checkbox"/>	Thoughts of hurting myself	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	Thoughts of hurting someone else	<input type="checkbox"/>
Blood in stools	<input type="checkbox"/>	Endocrine	
Involuntary loss of gas or stools	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>
Urinary		Heat intolerance	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	Cold intolerance	<input type="checkbox"/>
Pain with urination	<input type="checkbox"/>	Abnormal thirst	<input type="checkbox"/>
Strong urgency to urinate	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>
Incomplete emptying	<input type="checkbox"/>	Hematologic / Lymphatic	
Involuntary / unintended urine loss	<input type="checkbox"/>	Frequent bruises	<input type="checkbox"/>
Urine loss when coughing or lifting	<input type="checkbox"/>	Cuts that do not stop bleeding	<input type="checkbox"/>
Frequent urination at night	<input type="checkbox"/>	Enlarged lymph nodes (glands)	<input type="checkbox"/>
Difficulty urinating	<input type="checkbox"/>	Allergic	
		Ear fullness	<input type="checkbox"/>
		Itchy eyes	<input type="checkbox"/>
		Runny nose	<input type="checkbox"/>
		Sinus congestion	<input type="checkbox"/>