

**FLOWER MOUND WOMEN'S CARE**  
**ODETTE LIMOSNERO, M.D., P.A. GUY VAN DELL, M.D., P.A.**

*Obstetrics & Gynecology*

400 Parker Square Suite 245 Flower Mound, TX 75028  
 Tel. 972-899-9787 Fax. 972-899-9786 <http://www.fmwomenscare.com>

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

**Has any of your contact or insurance information changed since your last visit? If yes, please state:**

Personal contact     yes     no  
 Insurance info       yes     no

**For what reason are you seeing the doctor?**

❖ Please describe your problem including where it is, how severe it is, and how long it's lasted.

❖ Is this a new problem?     yes     no

**Current medications**

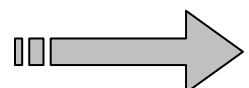
(Including hormones, vitamins, herbs, nonprescription medications)

Drug name	Dosage	Who prescribed	Month / Year began taking

**Please list any of the following changes since your last visit:**

New Medical Problems			
New Surgeries			
Hospitalizations	Reason	Date	Hospital
Changes in family medical history			
New Allergies			

**Please turn over for a review of current symptoms on other side**



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Name: \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_

**Review of Current Symptoms**

(Check all that apply)

Constitutional		Notes
Weight loss	<input type="checkbox"/>	
Weight gain	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	
Change in height	<input type="checkbox"/>	
Cardiovascular		Notes
Chest pain or pressure	<input type="checkbox"/>	
Difficulty breathing on exertion	<input type="checkbox"/>	
Palpitations	<input type="checkbox"/>	
Respiratory		Notes
Wheezing	<input type="checkbox"/>	
Spitting up blood	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	
Chronic cough	<input type="checkbox"/>	
Gastrointestinal		Notes
Frequent diarrhea	<input type="checkbox"/>	
Blood in stools	<input type="checkbox"/>	
Nausea/Vomiting/Indigestion	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	
Genitourinary		Notes
Blood in urine	<input type="checkbox"/>	
Pain with urination	<input type="checkbox"/>	
Strong urgency to urinate	<input type="checkbox"/>	
Frequent urination	<input type="checkbox"/>	
Incomplete emptying	<input type="checkbox"/>	
Involuntary / unintended urine loss	<input type="checkbox"/>	
Urine loss when coughing or lifting	<input type="checkbox"/>	
Irregular periods	<input type="checkbox"/>	
Painful periods	<input type="checkbox"/>	
Premenstrual syndrome (PMS)	<input type="checkbox"/>	
Painful intercourse	<input type="checkbox"/>	
Abnormal vaginal discharge	<input type="checkbox"/>	
Breasts		Notes
Pain in breasts	<input type="checkbox"/>	
Nipple discharge	<input type="checkbox"/>	
Lumps	<input type="checkbox"/>	
Psychiatric		Notes
Depression or frequent crying	<input type="checkbox"/>	
Severe anxiety	<input type="checkbox"/>	
Endocrine		Notes
Hair loss	<input type="checkbox"/>	
Heat/Cold intolerance	<input type="checkbox"/>	
Abnormal thirst	<input type="checkbox"/>	
Hot flashes	<input type="checkbox"/>	
Hematological/Lymphatic		Notes
Frequent bruises	<input type="checkbox"/>	
Cuts that do not stop bleeding	<input type="checkbox"/>	