**PINEVIEW GYNECOLOGY**

**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Nickname**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for your visit today: 🞎** Annual Well-Woman Exam 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **City/State:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GYNECOLOGIC HISTORY:**

Last Menstrual Period: \_\_\_\_\_ Age of First Period:\_\_\_\_\_ Period every \_\_\_\_\_days Lasts \_\_\_\_\_ days

🞎 Heavy 🞎 Cramps

\*Last Pap Smear\_\_\_\_\_\_\_\_\_\_ History of Abnormal Pap: 🞎 Yes 🞎 No

\*Did your mother take the drug DES while she was pregnant with you? 🞎 Yes 🞎 No

Gardasil/HPV Vaccine\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sexually Active:** 🞎 Yes 🞎 Not Currently 🞎 Never 🞎 Male Partner 🞎 Female Partner

\*Did you begin sexual activity before the age of 16? 🞎 Yes 🞎 No

\*Have you had 5 or more sexual partners? 🞎 Yes 🞎 No

Current Contraception Method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Past Contraceptives:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*History of Sexually Transmitted Infections:**

Trichomonas\_\_\_\_\_ Gonorrhea\_\_\_\_\_ Chlamydia\_\_\_\_\_ Genital Warts\_\_\_\_\_ Syphilis\_\_\_\_\_ HPV\_\_\_\_\_ HIV\_\_\_\_\_

Have you been tested for HIV or Hepatitis?\_\_\_\_\_\_\_

Last Mammogram and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you do regular Breast Self-Exams: 🞎 Yes 🞎 No

Hysterectomy: Year \_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_

Age of Menopause: \_\_\_\_\_\_

Colonoscopy: 🞎 No 🞎 Yes-Year/Location/Provider/Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous DEXA Bone Density Scan: 🞎 No 🞎 Yes - Year\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

Do you drink Alcohol? 🞎Never 🞎Rare 🞎Occasional Drinks/week\_\_\_\_\_\_\_\_\_\_

How many times in the last year have you had more than 4 drinks in a day?\_\_\_\_\_\_\_\_\_\_

Do you smoke cigarettes? 🞎No 🞎Yes Years smoking\_\_\_\_\_ Packs/day\_\_\_\_\_\_\_ 🞎Quit smoking \_\_\_\_\_\_ (year)

What is your diet like? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you exercise regularly? 🞎Yes 🞎 No

Are you: 🞎 Single 🞎 Married 🞎 Engaged 🞎 Separated 🞎 Divorced 🞎 Widowed 🞎 Living with Partner

School Completed: 🞎High school 🞎College 🞎 Graduate Degree 🞎Other\_\_\_\_\_\_\_\_\_\_\_\_

What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use any illicit drugs? 🞎 Yes 🞎 No Do you wear your seatbelt? 🞎 Yes 🞎 No

Do you have Advance Directives in place? (Living Will and/or Medical Power of Attorney) Yes No

**Personal Safety:**

Has anyone ever threatened to hurt you? 🞎 Yes 🞎 No

Has anyone ever hit, kicked, choked, or hurt you physically? 🞎 Yes 🞎 No

Has anyone, including your partner ever forced you to have sex? 🞎 Yes 🞎 No

Are you ever afraid of your partner? 🞎 Yes 🞎 No

**OBSTETRICAL HISTORY:**

Number of Pregnancies: \_\_\_\_\_ Full-Term Births: \_\_\_\_\_ Pre-term Births: \_\_\_\_\_ # of Weeks\_\_\_\_\_

Miscarriages:\_\_\_\_\_ Abortions: \_\_\_\_\_ Ectopic/Tubal Pregnancies:\_\_\_\_\_ Living Children:\_\_\_\_\_

C-Section: \_\_\_\_\_ Vaginal Delivery\_\_\_\_\_ Complications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Complete Reverse Side\***

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy Name/Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications/Dose/Frequency:** Include vitamins, herbal, and over the counter medicines

|  |  |
| --- | --- |
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

**Last Immunization (date):**

Flu Shot\_\_\_\_\_\_\_\_\_\_\_ Pneumonia Vaccine\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies/Reactions:**

|  |  |
| --- | --- |
| 1. | 3. |
| 2. | 4. |
| 🞎 **No Known Drug Allergies** |  |

**PAST MEDICAL HISTORY:**

|  |  |  |
| --- | --- | --- |
| 🞎High Blood Pressure  🞎High Cholesterol | 🞎GERD/Reflux  🞎Diarrhea/Constipation | 🞎 Seizures/Convulsions/Epilepsy  🞎Arthritis |
| 🞎 Heart Disease/Heart Failure | 🞎 Thyroid Disease | 🞎 Cataracts/Macular Degeneration |
| 🞎 Heart Attack | 🞎Pneumonia | 🞎Glaucoma |
| 🞎 Heart Murmur | 🞎Asthma | 🞎Blood Clots |
| 🞎Diabetes | 🞎 Chronic Lung Disease | 🞎Osteoporosis/Osteopenia |
| 🞎Stroke | 🞎 Kidney Infections/Stones | 🞎 Hepatitis/Jaundice |
| 🞎 Rheumatic Fever | 🞎 Migraines | 🞎 Fractures |
| 🞎Sleep Apnea | 🞎 Depression/Anxiety | 🞎Cancer, Type **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  | Ashkenazi Jewish Descent | 🞎Other **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**SURGICAL HISTORY: Please list all surgeries and biopsies**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date (Year)** | **Procedure** | **Date (Year)** | **Procedure** |
|  |  |  |  |
|  |  |  |  |

Have you ever had any problems with Anesthesia? 🞎 Yes 🞎 No Blood Transfusion? 🞎 Yes 🞎 No

**FAMILY HISTORY:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease** | **Family Relation** | **Maternal/ Paternal Side** | **Age Diagnosed** | **Age of Death** |
| 🞎 High Blood Pressure |  |  |  |  |
| 🞎 Diabetes |  |  |  |  |
| 🞎 Heart Attack |  |  |  |  |
| 🞎 Heart Disease |  |  |  |  |
| 🞎 Stroke |  |  |  |  |
| 🞎 Suicide |  |  |  |  |
| 🞎 Thyroid Disease |  |  |  |  |
| 🞎 Drinking Problem |  |  |  |  |
| 🞎 Blood Clots |  |  |  |  |
| 🞎 Breast Cancer |  |  |  |  |
| 🞎 Ovarian Cancer |  |  |  |  |
| 🞎 Uterine Cancer |  |  |  |  |
| 🞎 Colon Cancer |  |  |  |  |
| 🞎 Other Cancer, Type |  |  |  |  |