

PINEVIEW GYNECOLOGY

Name: _____ **Nickname:** _____ **DOB:** _____

Ethnic Group: Hispanic or Latino Not Hispanic or Latino

Race: American Indian Asian African American Caucasian Pacific Islander Other _____

Language: English Spanish Arabic Hebrew Cantonese Hebrew Japanese Korean
 Mandarin Russian Other _____

Referred by: _____ **Primary Care Doctor:** _____

Reason for your visit today:

Annual Well-Woman Exam Other: _____

Past Medical History:

- | | | |
|---|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> Anxiety/Panic Attacks |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cataracts/Macular Degeneration |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diverticulosis/Diverticulitis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Headaches | <input type="checkbox"/> Cancer, Type _____ |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Depression | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Gardasil/HPV Vaccine,
Dates Given _____ | | |

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

Gynecologic History:

Last Menstrual Period: _____
 Age of First Period: _____
 Period every _____ days. Lasts _____ days.
 Heavy periods Cramps PMS/Moodiness
 Last Pap Smear _____
 History of Abnormal Pap: Yes No
 Treatment for Abnormal Pap: Yes No
 Sexually Active: Yes Not Currently Never
 Male Partner Female Partner
 History of STDs: Yes No
 Contraception Method: _____
 Do you do regular Breast Self Exams: Yes No
 Last Mammogram and Location: _____
 Hysterectomy: Year _____ Age _____
 Age of Menopause: _____ Menopausal Symptoms: Hot Flashes Night Sweats Decreased Libido
 Colonoscopy: No Yes-Year/Location/Provider/Results _____
 Previous DEXA Bone Density Scan: No Yes-Year _____

Obstetrical History:

Number of Pregnancies: _____
 Number of Full-Term Births: _____
 Number of Pre-term Births: _____ Weeks _____
 Miscarriages: _____ Abortions: _____
 Ectopic/Tubal Pregnancies: _____
 Multiple Births: _____
 Living Children: _____
 Largest Baby: _____ lbs. _____ oz.
 C-Section: _____
 Complications: _____ None

Complete Reverse Side

Reviewed By:
Date:

Name: _____ DOB: _____

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

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Allergies/Reaction

1.	4.
2.	5.
3.	6.
<input type="checkbox"/> No Known Drug Allergies	

Pharmacy Name/Location/Phone Number: _____

Social History

Do you drink Alcohol? Never Rare Occasional ___ drinks/week
 Do you smoke cigarettes? No Yes ___ packs/day quit smoking ___ (year)
 What is your diet like? _____ Calcium Daily Intake: _____ mg None Don't Know
 Are you: single married engaged separated divorced widowed living with partner
 Do you exercise regularly? Yes No
 What is your occupation? _____
 Use any illicit drugs? Yes No
 Do you wear your seatbelt? Yes No
 Have you ever been abused? No Physically Sexually Emotionally
 Are your Immunizations up to date? Yes No

Family History:

Disease	Family Relation	Age Diagnosed	Age of Death
<input type="checkbox"/> High Blood Pressure			
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> Heart Attack/Heart Problems			
<input type="checkbox"/> Stroke			
<input type="checkbox"/> Kidney Stones			
<input type="checkbox"/> Depression/Anxiety			
<input type="checkbox"/> Thyroid Disease			
<input type="checkbox"/> Elevated Cholesterol			
<input type="checkbox"/> Osteoporosis			
<input type="checkbox"/> Breast Cancer			
<input type="checkbox"/> Ovarian Cancer			
<input type="checkbox"/> Uterine Cancer			
<input type="checkbox"/> Colon Cancer			
<input type="checkbox"/> Other Cancer, Type			
<input type="checkbox"/> OTHER:			

Reviewed By: Date:
