STAFF USE

Account #: _____

Today's Date: _____ Age: _____

Name: _____ Pref. Name: _____

Fort Sanders Obstetrical & Gynecological Group, P.C.®

Reason for Today's Visit: **New Patient** **Annual** **Follow-Up** **Problem Visit** **Post-Op** **Postpartum**

Since Your Last Visit:

Chronic Health Issues e.g. Diabetes, Thyroid, Blood Pressure: _____

_____

GYN, Bladder or Pelvic Issues: _____

Gynecological History:

Last Menstruation Period: _____ Last Annual Exam: _____

Last Pap Smear: _____ Ever had an abnormal pap smear? **Y** **N**

If yes, what treatment did you receive?: _____

Do you have heavy, bothersome menstruation periods? **Y** **N**

# of Pregnancies: _____ # of Live Births: _____ # of Vaginal Births: _____ # of C-Sections: _____

Age at First Child: _____ Age at First Period: _____ If Menopausal, Age at Last Period: _____

Patient History:

Drug Allergies: _____

Current Medications: _____

_____

Operations: _____

Last Mammogram (over 40): _____ Do you do self breast exams? **Y** **N**

Last Colonoscopy (over 50): _____

Ever had a Bone Density Scan? **Y** **N** When: _____ Ever had a Thyroid Test? **Y** **N** When: _____

Last Cholesterol Screening: _____ Have you had the HPV vaccine (cervical cancer vaccine)? **Y** **N**

Do you smoke? **Y** **N** Do you drink? **Y** **N** Do you do recreational drugs? **Y** **N** Kind: _____

Are you currently sexually active? **Y** **N** Have you ever been sexually active? **Y** **N**

Current Birth Control (circle): IUD, Birth Control Pills, Implant, Depo, Rhythm Method, Condoms, Foam, Vasectomy, Hysterectomy

Family History:

History of Breast, Colon, Ovarian Cancer, and relationship to you: _____

Bleeding or Clotting Disorders, and relationship to you: _____

Diabetes, Early Heart Disease, Kidney Disease, Blood Pressure, Thyroid, Auto Immune or other medical problems? _____

_____

_____

Please See Other Side

Review of Symptoms

Patient Name: _____ Date: _____

Since your last visit have you experienced **Please answer Y or N to the following**

General Health		
Y	N	Appetite Loss
Y	N	Fever
Y	N	High Blood Pressure
Y	N	Recent Weight Gain/ Loss
Y	N	Unusual Weakness/ Fatigue

Other:

Head / Neck		
Y	N	Hearing Loss
Y	N	Nose Bleeds
Y	N	Runny Nose
Y	N	Sore Throat/ Hoarseness
Y	N	Throat Swelling

Other:

Cardiovascular		
Y	N	Leg Swelling
Y	N	Palpitations
Y	N	Shortness of Breath When Lying Flat
Y	N	Slow/ Rapid Heart Beat

Other:

Respiratory		
Y	N	Chest Pain/ Breathing
Y	N	Coughing or Wheezing
Y	N	Difficulty Breathing with Activity
Y	N	Shortness of Breath

Other:

Muscles / Joints		
Y	N	Pain or Stiffness

Other:

Genitourinary		
Y	N	Abnormal Pap Smears
Y	N	Bleeding between periods, after menopause or irregular periods
Y	N	Heavy Vaginal Bleeding/ Painful Bleeding
Y	N	Painful Intercourse
Y	N	Painful or Frequent Urination
Y	N	Sexually Transmitted Diseases
Y	N	Vaginal Discharge

Other:

Breast / Skin		
Y	N	Abrasions or Lacerations
Y	N	Do you perform monthly self exams?
Y	N	Lumps, Masses or Discharge
Y	N	Rash, Bruising or Swelling

Other:

Hematology		
Y	N	Anemia/ Blood Transfusion
Y	N	Easy Bruising/ Abnormal Bleeding
Y	N	Swollen Lymph Nodes

Other:

Gastrointestinal		
Y	N	Blood in Stool or Black Tarry Stool
Y	N	Constipation or Diarrhea
Y	N	Nausea or Vomiting
Y	N	Pain or Bloating

Other: