STAFF USE

Account #: _____ Today's Date: _____ Age: _____

Name: _____ Pref. Name: _____

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

Circle Reason for Visit: New Patient Annual Exam Problem Visit Follow Up PostOp Postpartum

Date of: Last Pap: _____ Last Mammogram: _____

Last Colonoscopy: _____ Last Bone Density Scan: _____

Concerns to address today: _____

Current medication list: _____

Drug allergies: _____

Below is to be competed for Annual Exam and New Patients only.

Chronic Health Problems: (Circle) Hypertension High Cholesterol Diabetes Hypothyroidism

Other: _____

Past Surgeries: _____

Gynecologic History: Last Menstrual Period: _____ Age at First Period: _____

Have you had the HPV vaccine? **Y N** If Menopausal, Age of Last Period: _____

History of Abnormal Pap Smears: **Y N** History of HPV or Dysplasia: **Y N**

Treatments Done: Biopsy LEEP Cone Cryo (freezing) Laser Other: _____

Are you Sexually Active? **Y N** Sexual Preference: Men Women Both

Current form of Birth Control: Pills Patch VaginalRing Shot IUD ArmImplant TubalSterilization Vasectomy

Condoms RhythmMethod Other: _____

Obstetric History: Total Number of Pregnancies: _____ Number of Live Births: _____ Your Age at First Childbirth: _____

Number of Vaginal Deliveries: _____ Number of C-Sections: _____

Social History: Tobacco Use: **Y N** How much in a week? _____ How many years? _____

Alcohol Use: **Y N** Daily Alcohol Use: **Y N** How many servings in a typical week? _____

Recreational Drug Use: **Y N** Type: _____ How often? _____

Occupation: _____ Type/Frequency of Exercise: _____

Pertinent Family History: *List family member/age at diagnosis.*

Breast Cancer: _____

Ovarian Cancer: _____ Colon/GI Cancer: _____

Diabetes Mellitus: _____ Early Heart Disease (<age50): _____

Autoimmune Diseases: _____ Blood Clotting Diseases: _____

Genetic Diseases: _____ Other: _____

Continue to other side.

Review of Symptoms

Patient Name: _____

Please check ✓ the following sypmtoms you have experienced since your last visit:

General Health

- ❑ Unusual weakness/fatigue
- ❑ Recent weight gain/loss
- ❑ Appetite loss
- ❑ Fever
- ❑ Difficulty sleeping
- ❑ Chronic pain
- ❑ Do you wear seat belts?

Mental Health/Neurological

- ❑ Feeling sad/depressed often
- ❑ Feeling anxious often
- ❑ Thoughts of harming yourself
- ❑ Abuse of alcohol/drugs
- ❑ Memory changes
- ❑ Confusion
- ❑ Seizure activity
- ❑ Frequent headaches
- ❑ Balance problems
- ❑ Numbness
- ❑ Loss of consciousness

Skin / Hair

- ❑ Hair loss
- ❑ Skin rash
- ❑ Excessive itchiness
- ❑ Skin growths
- ❑ Non-healing sores
- ❑ Moles changing size/color/shape

Head / Neck

- ❑ Vision loss
- ❑ Hearing loss
- ❑ Sore throat
- ❑ Difficulty swallowing
- ❑ Ear pain or discharge
- ❑ Frequent nose bleeds
- ❑ Mouth ulcers/sores

Cardiovascular / Respiratory

- ❑ Chest pain or pressure
- ❑ Heart palpitations
- ❑ Shortness of breah
- ❑ Coughing/wheezing
- ❑ Snoring or breathing pauses in sleep

Hematology

- ❑ History of anemia
- ❑ History of blood tranfusion
- ❑ Easy bruising
- ❑ History of excessive bleeding
- ❑ Swollen lymph nodes

Gastrointestinal

- ❑ Abdominal pain
- ❑ Bloating
- ❑ Abdominal swelling/distention
- ❑ Constipation
- ❑ Diarrhea
- ❑ Bloody or tarry stool

Genitourinary

- ❑ Pain with urination
- ❑ Blood in urine
- ❑ Urinary incontinence
- ❑ Difficulty emptying bladder
- ❑ Frequent nighttime urination
- ❑ Vaginal bleeding after menopause
- ❑ Irregular vaginal bleeding
- ❑ Heavy menses
- ❑ Painful menses
- ❑ Painful intercourse
- ❑ Abnormal vaginal discharge
- ❑ History of Sexually Transmitted Infection

Breast Health

- ❑ Rash or Sore
- ❑ Lumps or masses
- ❑ Nipple discharge
- ❑ Pain in breasts
- ❑ New-onset nipple retraction
- ❑ Do you do monthly self exams?

_____ _____

Patient Signature Date