



Name	Home Phone	Marital Status	Date
Street Address	Work Phone	Birthdate	
City, State, Zip	Insurance Carrier/ID#/Group#/Phone#	Email Address	

ESTABLISHED PATIENTS

What brings you to the office today?

Annual Exam / Routine Care
 Lab Work / STD Testing
 OB Visit
 Problem / Issue (Please describe briefly)
 Procedure

Medications

Any changes in your medications and / or supplements since your last visit?

Vaccines

What vaccines have you received since your last visit here? (please list vaccines)	Date of Vaccination (the year only is fine)

Allergies / Adverse Reactions: Do you have any new allergies since your last visit?

Are you allergic to anything? (please list allergens)	What kind of reaction do you have? (please describe the reaction you experience to each)

Medical History: Please describe any changes in your medical history since your last visit.

For example, do you have any new medical conditions or concerns?

Diagnostic Tests: Have you received any recent diagnostic test? (For example, Ultrasound, NST, Mammogram, CT Scan, etc.)

What diagnostic tests have you received since your last visit here? (please list tests)	Date of Test (month and year)

Social History: Please describe any changes in your social history since your last visit.

For example, have you experienced any changes in your education, employment, family life, social life, or lifestyle?

Family History: Have there been any changes in your family history since your last visit?		
List health condition below.	Date of Occurrence	Relationship

GYN History			
Date of Last Menstrual Period			
Frequency of Menstrual Period	EVERY DAYS	LASTING DAYS	LIGHT / NORMAL / HEAVY
Last Pap Smear	NORMAL / ABNORMAL		
Last Mammogram	NORMAL / ABNORMAL		
Current Method of Contraception			

OB History: Please describe any changes in your OB history since your last visit.

Have you had any new problems with any of the following since your last visit?				
General <input type="checkbox"/> Weight Loss or Gain <input type="checkbox"/> Fevers <input type="checkbox"/> Trouble Sleeping <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Abnormal Thirst	Lungs <input type="checkbox"/> Coughing Up Blood <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Blood Clot in the Lungs <input type="checkbox"/> Painful Breathing <input type="checkbox"/> Wheezing	Musculoskeletal <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Joint Pains <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Clot in Leg Vein	Menstrual Problems <input type="checkbox"/> Cramps/Pain <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Too Frequent Periods <input type="checkbox"/> Bleeding Between Periods <input type="checkbox"/> Missed a Period <input type="checkbox"/> Other Period Issue	Other Gynecologic Issues <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Itching/Irritation <input type="checkbox"/> Vulvar Pain <input type="checkbox"/> Vulvar lump/growth <input type="checkbox"/> Vulvar Sores
Eyes <input type="checkbox"/> Itchy, Red Eyes <input type="checkbox"/> Vision Problems	Cardiovascular <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Ankle/Hand Swelling	Neurologic <input type="checkbox"/> Frequent/Severe Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness <input type="checkbox"/> Trouble Walking <input type="checkbox"/> Fainting Spells	Pre Menstrual Problems <input type="checkbox"/> Bloating/Swelling <input type="checkbox"/> Mood Changes <input type="checkbox"/> Breast Changes <input type="checkbox"/> Headaches <input type="checkbox"/> Acne <input type="checkbox"/> Other PMS Issue	Sexual Problems <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Bleeding after Intercourse <input type="checkbox"/> Decreased Desire <input type="checkbox"/> Orgasm Problems <input type="checkbox"/> Dryness <input type="checkbox"/> Possible Exposure to STD <input type="checkbox"/> Other Sexual Issue
Ears <input type="checkbox"/> Ear Pain <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Hearing Loss	Gastrointestinal <input type="checkbox"/> Frequent Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody Stools <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Hemorrhoids	Skin <input type="checkbox"/> Acne <input type="checkbox"/> Unwanted Hair Growth <input type="checkbox"/> Unusual Lump or Growth <input type="checkbox"/> Dry Skin	Menopause Issues <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Night Sweats	Would you like to discuss any of the following? <input type="checkbox"/> Contraception <input type="checkbox"/> Menopause Issues <input type="checkbox"/> Pregnancy Issues <input type="checkbox"/> Self Breast Exam <input type="checkbox"/> Sexuality Issues <input type="checkbox"/> STDs <input type="checkbox"/> Other
Nose <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nose Bleeds	Urinary <input type="checkbox"/> Incomplete Urination <input type="checkbox"/> Loss of Urine <input type="checkbox"/> Painful Urination <input type="checkbox"/> Bloody Urine	Emotional <input type="checkbox"/> Excessive Worry <input type="checkbox"/> Depression <input type="checkbox"/> Frequent Crying <input type="checkbox"/> Serious thoughts of harming yourself or others	Breast Problems <input type="checkbox"/> Breast Pain <input type="checkbox"/> Breast Lump <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Other Breast Issue	

Signature