SEEBABY PERINATAL SEEBABY MIDWIFERY SEEBABY GYNECOLOGY

Name	Home Phone	Marital Status	Date
Street Address	Work Phone	Birthday	
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?

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
__ Weight Loss or Gain
__ Fevers
__ Trouble Sleeping
__ Chronic Fatigue
__ Excessive Bleeding
__ Easy Bruising
__ Abnormal Thirst

Eyes
__ Itchy, Red Eyes
__ Vision Problems

Ears
__ Ear Pain
__ Ringing in Ears
__ Hearing Loss

Nose
__ Sinus Problems
__ Nose Bleeds

Mouth
__ Sore Throat
__ Mouth Sores
__ Dental Problems

Lungs
__ Coughing Up Blood
__ Shortness of Breath
__ Chronic Cough
__ Blood Clot in the Lungs
__ Painful Breathing
__ Wheezing

Cardiovascular
__ Chest Pain
__ Irregular Heart Beat
__ Ankle/Hand Swelling

Gastrointestinal
__ Frequent Diarrhea
__ Constipation
__ Bloody Stools
__ Nausea/Vomiting
__ Hemorrhoids

Urinary
__ Incomplete Urination
__ Loss of Urine
__ Painful Urination
__ Bloody Urine

Musculoskeletal
__ Muscle Weakness
__ Joint Pains
__ Joint Swelling
__ Clot in Leg Vein

Neurologic
__ Frequent/Severe Headaches
__ Dizziness
__ Seizures
__ Numbness
__ Trouble Walking
__ Fainting Spells

Skin
__ Acne
__ Unwanted Hair Growth
__ Unusual Lump or Growth
__ Dry Skin

Emotional
__ Excessive Worry
__ Depression
__ Frequent Crying
__ Serious thoughts of harming yourself or others

Menstrual Problems
__ Cramps/Pain
__ Heavy Bleeding
__ Too Frequent Periods
__ Bleeding Between Periods
__ Missed a Period
__ Other Period Issue

Pre Menstrual Problems
__ Bloating/Swelling
__ Mood Changes
__ Breast Changes
__ Headaches
__ Acne
__ Other PMS Issue

Menopause Issues
__ Hot Flashes
__ Night Sweats

Breast Problems
__ Breast Pain
__ Breast Lump
__ Nipple Discharge
__ Other Breast Issue

Other Gynecologic Issues
__ Vaginal Discharge
__ Itching/Irritation
__ Vulvar Pain
__ Vulvar lump/growth
__ Vulvar Sores

Sexual Problems
__ Painful Intercourse
__ Bleeding after Intercourse
__ Decreased Desire
__ Orgasm Problems
__ Dryness
__ Possible Exposure to STD
__ Other Sexual Issue

Would you like to discuss any of the following?
__ Contraception
__ Menopause Issues
__ Pregnancy Issues
__ Self Breast Exam
__ Sexuality Issues
__ STDs
__ Other

Signature