FLOWER MOUND WOMEN'S CARE

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Obstetrics & Gynecology

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Name: _____ Date:_____ Age: _____

Has any of your contact or insurance information changed since your last visit? If yes, please state:

Personal contact □ **yes** □ **no**
Insurance info □ **yes** □ **no**

For what reason are you seeing the doctor?

Please describe your problem including where it is, how severe it is, and how long it's lasted.

Is this a new problem? □ **yes** □ **no**

Current medications
(Including hormones, vitamins, herbs, nonprescription medications)

Drug name	Dosage	Who prescribed	Month / Year began taking

Please list any of the following changes since your last visit:

New Medical Problems			
New Surgeries			
Hospitalizations	Reason	Date	Hospital
Changes in family medical history			

New Allergies		

Please turn over for a review of current symptoms on other side **FLOWER MOUND WOMEN'S CARE**

Review of Current Symptoms (Check all that apply)		
Constitutional		**Notes**
Weight loss	□	
Weight gain	□	
Fever	□	
Change in height	□	
Cardiovascular		**Notes**
Chest pain or pressure	□	
Difficulty breathing on exertion	□	
Palpitations	□	
Respiratory		**Notes**
Wheezing	□	
Spitting up blood	□	
Shortness of breath	□	
Chronic cough	□	
Gastrointestinal		**Notes**
Frequent diarrhea	□	
Blood in stools	□	
Nausea/Vomiting/Indigestion	□	
Constipation	□	
Genitourinary		**Notes**
Blood in urine	□	
Pain with urination	□	
Strong urgency to urinate	□	
Frequent urination	□	
Incomplete emptying	□	
Involuntary / unintended urine loss	□	
Urine loss when coughing or lifting	□	
Irregular periods	□	
Painful periods	□	
Premenstrual syndrome (PMS)	□	
Painful intercourse	□	
Abnormal vaginal discharge	□	
Breasts		**Notes**
Pain in breasts	□	

Nipple discharge	□	
Lumps	□	
Psychiatric		**Notes**
Depression or frequent crying	□	
Severe anxiety	□	
Endocrine		**Notes**
Hair loss	□	
Heat/Cold intolerance	□	
Abnormal thirst	□	
Hot flashes	□	
Hematological/Lymphatic		**Notes**
Frequent bruises	□	
Cuts that do not stop bleeding	□	