

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)

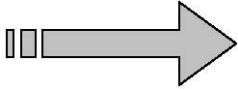
Drug name	Dosage	Who prescribed	Month / Year began taking

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

Nipple discharge	<input type="checkbox"/>	
Lumps	<input type="checkbox"/>	
Psychiatric		Notes
Depression or frequent crying	<input type="checkbox"/>	
Severe anxiety	<input type="checkbox"/>	
Endocrine		Notes
Hair loss	<input type="checkbox"/>	
Heat/Cold intolerance	<input type="checkbox"/>	
Abnormal thirst	<input type="checkbox"/>	
Hot flashes	<input type="checkbox"/>	
Hematological/Lymphatic		Notes
Frequent bruises	<input type="checkbox"/>	
Cuts that do not stop bleeding	<input type="checkbox"/>	