FLOWER MOUND WOMEN'S CARE

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Obstetrics & Gynecology

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Name: _____ Date:_____ Age: _____

Name of Primary Care Physician: _____

For what reason are you seeing the doctor? * **if there is a question you do not feel comfortable answering, you can leave it blank and we will go over it in the visit if necessary.**

- ❖ Is this a new problem?
- ❖ Please describe your problem including where it is, how severe it is, and how long it's lasted.

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

Drug name	Dosage	Who prescribed	Month / Year began taking
1			
2			
3			
4			
5			

Personal Past History of Illnesses

Major Illnesses	Yes (Date)	No	Major Illnesses	Yes (Date)	No
Asthma			Reflux / Hiatal Hernia / Ulcers		
Pneumonia / Lung disease			Depression / Anxiety		
Migraine Headaches			Anemia		
Kidney Infections / Stones			Blood Transfusions		
Tuberculosis			Seizures / Convulsions / Epilepsy		
HIV / AIDS			Bowel Problems		
Heart Attack / Problems			Glaucoma		
Diabetes			Cataracts		
High Blood Pressure			Arthritis / Joint / Back Problems		
Stroke			Broken Bones		
Rheumatic Fever			Hepatitis / Yellow Jaundice / Liver Disease		
Eating Disorders			Thyroid Disease		
Collagen Vascular Disease (Lupus)			Gallbladder Disease		
Chicken Pox			Headaches		
			Other		

Allergies (Medications or Foods)

Medication or Food	Reaction	Medication or Food	Reaction

Gynecologic History

First day of last menstrual period: ___ /___ / ___	When was your last pap test?
Age period began:	What was the result?
Length of periods (number of days of bleeding):	Have you ever had an abnormal pap test?
Number of days between periods:	What treatments were taken? (cryo, freezing, LEEP, CONE)
Any recent changes in periods?	Have you ever been diagnosed with any STD's (HPV, HIV, genital warts, herpes, gonorrhea, Chlamydia, trichamonas, hepatitis, syphilis)?
Have you ever had sex?	
Are you currently sexually active?	Do you have a history of infertility?
Sexual partners are: ___men ___women ___both	Have you ever taken or are you taking HRT (hormone replacement therapy)?
Number of sexual partners (lifetime):	Have you ever had any of the following, if so when was the last time?
Present method of birth control:	Mammogram
List prior methods of birth control:	Bone Mineral Density Test
History of Endometriosis?	Screening for Colon Cancer
History of Fibroids?	(Occult blood test, sigmoidoscopy, colonoscopy)

Obstetric History

	Number		Number		Number
Pregnancies (total)		Miscarriages		Live Births	
Premature Births (<37 weeks)		Abortions		Living Children	

Pregnancies:

No	Date	Weeks Pregnant	Hours of Labor	Baby's Weight	Baby's Sex	Type of Delivery (vaginal / cesarean)	Type of anesthesia	Place of delivery	Complications
1									
2									
3									
4									
5									

Surgical History:

Operation	Date	Reason	Hospital

Hospitalizations (other than for surgery):

Reason	Date	Hospital

Family Medical History:

Mother: ___Living ___Deceased, cause_____ Age: **Father:** ___Living ___Deceased, cause_____ Age:

Siblings: Number living: _____ Number deceased: _____ cause(s)/ages:

Children: Number living: _____ Number deceased: _____ cause(s)/ages:

Illnesses	Yes	Which Relative(s) and age of onset
Diabetes	□	
Stroke	□	
Heart Disease	□	
Blood clots in lungs or legs	□	
High blood pressure	□	
High cholesterol	□	
Osteoporosis (weak bones)	□	
Hepatitis	□	
HIV / AIDS	□	
Tuberculosis	□	
Birth defects	□	
Drinking or Drug problems	□	
Breast Cancer	□	
Colon Cancer	□	
Uterine or Ovarian Cancer	□	
Mental illness / depression	□	
Alzheimer's Disease	□	
Other	□	

Social History

	yes	no		yes	no
Ever smoked? Current smoking: packs per day: years:	□	□	Regular Exercise?	□	□
Alcohol: Drinks per day Drinks per week:	□	□	Health hazards at home or work?	□	□
Recreational Drug use	□	□	Have you been sexually abused, threatened. or hurt by anyone?	□	□
Seat Belt use	□	□			

Sexual Orientation: ___heterosexual ___ homosexual ___ bisexual

Marital Status: ___ married ___ living with partner ___ single ___ widowed ___divorced

Number of living children:

School completed: ___ high school ___ some college / aa degree ___ college ___ graduate degree ___ other

Current or most recent job:

Travel outside the U.S.?

Hometown:

Review of *Current* Symptoms

(Check all that apply)

Constitutional		Female reproductive	
Weakness	□	Abnormal bleeding	□
Weight loss	□	Painful periods	□
Weight gain	□	Heavy periods	□
Fever	□	Premenstrual syndrome (PMS)	□
Fatigue	□	Painful intercourse	□
Change in height	□	Fibroids	□
Night sweats	□	Infertility	□
Loss of appetite	□	DES exposure	□
Eyes		Abnormal vaginal discharge	□
Double vision	□	Frequent yeast infections	□
Spots before eyes	□	Pelvic pain	□
Vision changes	□	**Musculoskelatal**	
Glasses / Contacts	□	Muscle weakness	□
Ears, Nose, Throat		Muscle or joint pain	□
Earaches	□	**Skin**	
Ringing in ears	□	Rash	□
Hearing problems	□	Dry skin	□
Sinus problems	□	Moles	□
Mouth sores	□	Hives	□
Cardiovascular		Lumps	□
Painful breathing	□	**Breasts**	
Chest pain or pressure	□	Pain in breasts	□
Difficulty breathing on exertion	□	Nipple discharge	□
Swelling of legs	□	Lumps	□
Palpitations	□	**Neurologic**	
Varicose veins	□	Dizziness	□
Dizziness	□	Seizures	□
Respiratory		Tingling / numbness	□
Wheezing	□	Trouble walking	□
Spitting up blood	□	Severe memory problems	□
Shortness of breath	□	Frequent or severe headaches	□
Chronic cough	□	Difficulty sleeping	□
Gastrointestinal		**Psychiatric**	
Nausea	□	Depression or frequent crying	□
Vomiting	□	Severe anxiety	□
Heartburn	□	High stress level	□
Abdominal pain	□	Sleep disturbances	□
Frequent diarrhea	□	Thoughts of hurting myself	□
Constipation	□	Thoughts of hurting someone else	□
Blood in stools	□	**Endocrine**	
Involuntary loss of gas or stools	□	Hair loss	□
Urinary		Heat intolerance	□
Blood in urine	□	Cold intolerance	□
Pain with urination	□	Abnormal thirst	□
Strong urgency to urinate	□	Excessive urination	□
Frequent urination	□	Hot flashes	□
Incomplete emptying	□	**Hematologic / Lymphatic**	
Involuntary / unintended urine loss	□	Frequent bruises	□
Urine loss when coughing or lifting	□	Cuts that do not stop bleeding	□
Frequent urination at night	□	Enlarged lymph nodes (glands)	□
Difficulty urinating	□	**Allergic**	
		Ear fullness	□
		Itchy eyes	□
		Runny nose	□
		Sinus congestion	□