

FamilyCare Initial Gyn History

Today's Date: _____ Name: _____ Date of Birth: _____ Age: _____

Marital Status: Married Single Divorced Widowed SSN: _____

Number we may reach you at in the daytime: _____ Alternate Contact Number: _____ May we contact you by mail?

Current Medications (Please list all prescription and over-the-counter medications you taking now)

List all allergies and adverse drug reactions:

What brings you to the office today?

Review of Systems: Do you currently (within the last month) have problems with the following?

General/Constitutional	<input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Hot Flashes
HEENT/Dental	<input type="checkbox"/> Vision problems <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Ringing in the Ears
	<input type="checkbox"/> Nasal Discharge <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Mouth/Tooth Pain
	<input type="checkbox"/> Sore Throat <input type="checkbox"/> Neck Pain <input type="checkbox"/> Limited Motion in Neck <input type="checkbox"/> Lumps or Swollen Glands in Neck
Breast	<input type="checkbox"/> Pain/Tenderness <input type="checkbox"/> Lump <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Changes in Skin of Breast
Respiratory	<input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Cough
Cardiovascular	<input type="checkbox"/> Chest Pain/Shortness of Breath with Exercise <input type="checkbox"/> Fatigue <input type="checkbox"/> Trouble breathing when laying flat
Extremities	<input type="checkbox"/> Pain/numbness in legs <input type="checkbox"/> Swelling <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Ulcers
Gastrointestinal	<input type="checkbox"/> Change in Appetite <input type="checkbox"/> Heartburn/Indigestion <input type="checkbox"/> Pain in Abdomen <input type="checkbox"/> Nausea/Vomiting
Urinary	<input type="checkbox"/> Painful Urination <input type="checkbox"/> Urinating Often (more than 8 times a day) <input type="checkbox"/> Getting up at night to urinate
	<input type="checkbox"/> Sudden urges to go to the bathroom <input type="checkbox"/> Leaking urine when you can't get to the bathroom in time
Gynecologic	<input type="checkbox"/> Vaginal itching or burning <input type="checkbox"/> Vaginal Odor and/or Discharge <input type="checkbox"/> Pain/Bleeding with sex
Musculoskeletal	<input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Limited Movement
Skin	<input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Change in color or size of a mole
Neurologic	<input type="checkbox"/> Seizures <input type="checkbox"/> Paralysis <input type="checkbox"/> Tremors <input type="checkbox"/> Difficulties with memory or speech
	<input type="checkbox"/> Difficulty with swallowing <input type="checkbox"/> Problems with coordination
Endocrine	<input type="checkbox"/> Increased Hunger <input type="checkbox"/> Increased Thirst <input type="checkbox"/> Intolerance to heat or cold
Psychiatric	<input type="checkbox"/> Depressed or irritable mood almost daily <input type="checkbox"/> Loss of interest or pleasure in activities
	<input type="checkbox"/> Inability to sleep <input type="checkbox"/> Sleeping too much <input type="checkbox"/> Constant fatigue or loss of energy
	<input type="checkbox"/> Frequent feelings of worthlessness <input type="checkbox"/> Frequent thoughts of death or suicide <input type="checkbox"/> Agitation

Family History Are you adopted? Yes No

Please Check the box if your birth parents, brothers, sisters, or children have any of the following:

Family Member	Family Member
<input type="checkbox"/> Birth/Genetic Defects _____	<input type="checkbox"/> High Cholesterol _____
<input type="checkbox"/> Blood Clots _____	<input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> Breast Disease _____	<input type="checkbox"/> Liver disease/hepatitis _____
<input type="checkbox"/> Bleeding Disorder _____	<input type="checkbox"/> Osteoporosis _____
<input type="checkbox"/> Cancer (Type) _____	<input type="checkbox"/> Sickle Cell _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Heart Attack before age 50 _____	<input type="checkbox"/> Thyroid Disease _____
<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Tuberculosis _____

When was your last dental exam? _____

Please list any surgeries and the year they were done _____

Past Medical History: Have you been diagnosed with, or treated for any of the following?

	Yes	No		Yes	No		Yes	No	Other/Comments
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness/Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Breast Disease/Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Hair Growth	<input type="checkbox"/>	<input type="checkbox"/>	
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	Severe Acne	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Strokes/Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bipolar/Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>				

Do you smoke? Yes No How many cigarettes per day? _____ How many years have you smoked? _____

Do you use Alcohol Yes No Number of drinks per day? _____ Numbers of drinks per week? _____

Do you use recreational drugs? Yes No What type? _____ How often? _____

Do you get regular exercise? Yes No What kind? _____ How many days per week? _____

Gynecologic/Obstetric History:

Age of first period: _____ Are your periods regular? _____ How many days are between period _____ How many days does period last? _____

First day of last period? _____ Was is normal? Yes No Do you have spotting between periods? Yes No

Are your periods: Light Moderate Heavy Do you have cramps? Yes No

Do you take any medications for PMS or cramps? Yes No What type? _____

Have you ever been pregnant? Yes No # of vaginal births _____ # of miscarriages _____

of abortions _____ # of cesarean sections _____ # of ectopic pregnancies _____

List any problems you had during pregnancy: _____

When was your last Pap Smear? _____ Was it normal? Yes No Have you ever had an abnormal pap smear? Yes No

When? _____ Did you receive treatment for the abnormal pap? Yes No What type? _____

Have you ever been diagnosed with or treated for any of the following?

<input type="checkbox"/> Pelvic Inflammatory Disease	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> HPV or genital warts	<input type="checkbox"/> Genital Herpes
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Fibroid tumors	<input type="checkbox"/> Trichomonas
<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Ovarian Cysts	

If you were born before 1972 did your mother take DES when she was pregnant with you? Yes No Don't Know

Are you currently sexually active? Yes No How many sexual partners have you had in the last year? _____

Are your partners Male Female Both Does your partner have partners other than you? _____

Does your partner use injectable drugs? Yes No Does your partner have HIV or Hepatitis? Yes No

Are you currently using any birth control method? Yes No What type? _____

How long have you used this method? _____ Describe any problems with it? _____

Have you ever used any of the following types of Birth Control?

<input type="checkbox"/> Pills	<input type="checkbox"/> Depo-Provera	<input type="checkbox"/> Lunelle	<input type="checkbox"/> Patch	<input type="checkbox"/> Vaginal Ring	<input type="checkbox"/> Hormone IUD	<input type="checkbox"/> Copper IUD	<input type="checkbox"/> Implant
<input type="checkbox"/> Diaphragm	<input type="checkbox"/> Condoms	<input type="checkbox"/> Foam/Spermicides	<input type="checkbox"/> Cervical Cap	<input type="checkbox"/> Withdrawal	<input type="checkbox"/> Rhythm/Natural Family Planning		

If you have had problems with these methods, please describe: _____

Do you want Birth Control today? Yes No What type? _____

Are you planning children in the next year? Yes No Undecided

I ACKNOWLEDGE THAT THE ABOVE IS CORRECT AND COMPLETE

PATIENT SIGNATURE: _____

REVIEWED BY: _____