

**FamilyCare Return GYN History**

Today's date: \_\_\_\_\_ Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed Telephone: \_\_\_\_\_

Is it ok to leave a voicemail with detailed information? \_\_\_\_\_

Email: \_\_\_\_\_ Is it okay to contact you by mail? \_\_\_\_\_ Email? \_\_\_\_\_

Who is your primary care provider? \_\_\_\_\_

Current Medications: (List all prescriptions and over the counter medications or supplements you are taking now)

\_\_\_\_\_

\_\_\_\_\_

What Pharmacy do you use and where is it located? \_\_\_\_\_

Allergies: \_\_\_\_\_

Has anything changed in your family medical history in the last year? \_\_\_\_\_

Has anything changed in your personal medical history in the last year? \_\_\_\_\_

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

<b>General</b>	<input type="checkbox"/> Unexplained Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> Fever <input type="checkbox"/> Hot flashes/Night sweats
	<input type="checkbox"/> Blurry Vision <input type="checkbox"/> Red Eyes <input type="checkbox"/> Vision Changes <input type="checkbox"/> Hearing Loss/Ears ringing
<b>HEENT/Dental</b>	<input type="checkbox"/> Ear Pain <input type="checkbox"/> Congestion <input type="checkbox"/> Sinus Pressure <input type="checkbox"/> Mouth/Tooth Pain
	<input type="checkbox"/> Sore Throat <input type="checkbox"/> Lumps or Swollen Glands in Neck <input type="checkbox"/> Neck Pain
<b>Breast</b>	<input type="checkbox"/> Pain/Tenderness <input type="checkbox"/> Lump <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Changes in Skin on Breast/Nipple
<b>Respiratory</b>	<input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough
<b>Cardiovascular</b>	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Trouble breathing when laying flat
<b>Extremities</b>	<input type="checkbox"/> Pain/numbness in legs <input type="checkbox"/> Swelling <input type="checkbox"/> Varicose Veins
<b>Musculoskeletal</b>	<input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Limited Movement
<b>Skin</b>	<input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Change in size or color of a mole
<b>Gastrointestinal</b>	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Diarrhea or Constipation
<b>Urinary</b>	<input type="checkbox"/> Painful urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Getting up at night to urinate
	<input type="checkbox"/> Sudden urges to go to the bathroom <input type="checkbox"/> Leaking urine
<b>Neurological</b>	<input type="checkbox"/> New or unusual Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling
<b>Endocrine</b>	<input type="checkbox"/> Increased hunger <input type="checkbox"/> Increased Thirst <input type="checkbox"/> Intolerance to heat or cold
	<input type="checkbox"/> Depressed or irritable Mood Almost Daily <input type="checkbox"/> Loss of interest or pleasure in activities
<b>Psychiatric</b>	<input type="checkbox"/> Changes in sleeping habits <input type="checkbox"/> Frequent feelings of worthlessness
	<input type="checkbox"/> Thoughts of harming yourself or others

**Personal History:** \_\_\_\_\_ When was your last mammogram? \_\_\_\_\_

When was your last dental exam? \_\_\_\_\_ When was your last eye exam? \_\_\_\_\_

When was your last tetanus booster? \_\_\_\_\_ How many HPV vaccines have you had? 0 1 2 3

If you are over the age of 50 have you had a colonoscopy? \_\_\_\_\_ If you are over 65 have you had a bone density test? \_\_\_\_\_

Are you currently sexually active? \_\_\_\_\_ How many sexual partners have you had in the last year? \_\_\_\_\_

Are you currently using any birth control method? \_\_\_\_\_ If yes what type? \_\_\_\_\_

Describe any problems with your current birth control method? \_\_\_\_\_

Do you want birth control today? \_\_\_\_\_ What type? \_\_\_\_\_

Are you planning children in the next year? \_\_\_\_\_

I ACKNOWLEDGE THAT THE ABOVE IS CORRECT AND COMPLETE

Patient signature: \_\_\_\_\_

Reviewed by: \_\_\_\_\_