WGM OB/GYN P.C.

PATIENT MEDICAL HISTORY Date:_____, 20_____

NAME_____ AGE _____ DOB_____

MENSTRUAL HISTORY:

Age Began: _____ Frequency: _____ Last Menses: _____

CONTRACEPTION:

Are you currently sexually active? _____ Male? _____ Female? _____ Both? _____

What method are you currently using? _____

Have you ever used? Pills____Diaphragm___IUD____Depo____Nuvaring_____Implant _____Sterilization____

Do you use condoms? _____

OBSTETRICAL HISTORY:

Year & Hospital	Sex	Weight	Vaginal or C-section Delivery	Any prenatal complications or problems with your delivery?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

MISCARRIAGES OR ABORTIONS:

Year	Hospital/Clinic	Doctor	Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

GYN SURGERY:

Procedure	Doctor	Hospital/Year
_____	_____	_____/_____
_____	_____	_____/_____
_____	_____	_____/_____

GYNECOLOGIC HISTORY:

Have you ever had or been diagnosed with any following? (if yes, please provide details)

Abnormal Pap smear_____

Fibroids _____

Ovarian cysts _____

STD's Chlamydia_____ Gonorrhea _____ Condyloma (genital warts) _____ Herpes_____

Date of last mammogram (month/year)_____

Date of last Pap smear (month/year)_____

Have you ever had the Gardasil vaccination? _____ If yes, when? _____

NAME_____

GENERAL SURGERY:

Procedure	Doctor	Hospital/Year
_____	_____	_____/_____
_____	_____	_____/_____
_____	_____	_____/_____

SOCIAL HISTORY: Tobacco: None _____ Packs per day:_____
Alcohol: None_____Daily:_____ Weekly:_____
Drug Abuse: _____
Are you now or have you ever been a victim of physical mental abuse? YES NO
Are you or have you ever been in the military?_____

MEDICAL HISTORY: Do you have or ever had any of the following medical conditions? If so, provide details:

Heart disease or high blood pressure

Lung disease (asthma, etc.) _____

Intestinal disorders (colitis, gallbladder disease, etc.) _____

Urinary tract disorders (infections, stones, etc.) _____

Muscular or skeletal problems (arthritis, etc.) _____

Psychiatric or emotional problems_____

Endocrine disorders (diabetes thyroid, etc.) _____

Breast disease_____

Migraine headaches_____

Blood clot disorder_____

Other _____

ALLERGIES: Drug _____ Reaction _____
Drug _____ Reaction _____
Drug _____ Reaction _____

NAME_____

CURRENT MEDICATIONS INCLUDING SUPPLEMENTS AND HERBS (include drug, dose and how often taken):

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

FAMILY HISTORY:

Mother (if alive): Age: _____ Medical Problem(s) _____

If deceased: Age_____ Cause of death_____

Father (if alive): Age: _____ Medical Problem(s) _____

If deceased: Age_____ Cause of death_____

Any family history of blood clotting disorder? _____

Any family history of strokes or heart attack before age 50?_____

FAMILY HISTORY OF CANCER (please list relative with type of cancer i.e. mother, sister, aunt, etc.)

Breast _____

Uterine_____

Ovarian_____

Colon _____

Prostate _____

FOR POST-MENOPAUSAL PATIENTS ONLY:

Age menses ceased: _____

Menopausal symptoms:_____

_____

Have you had a bone density test? _____ if yes, when?_____

Have you had a colonoscopy? _____ if yes, when?_____

REASON FOR TODAY'S VISIT:

_____

_____

_____

_____

_____

FAMILY DOCTOR:_____

Date of last complete physical:_____

NOTES:

Local Pharmacy (name & address)_____

Mail Away Pharmacy (phone & address)_____

PATIENT NAME:_____ DATE: _____ DOB:_____

AGE _____ LMP_____ WEIGHT _____ HEIGHT_____ BP_____HgB_____ Urine_____

CC:

ROS:

Thyroid NL ( ) ABNL ( )

Breast Left & Right ( )

Supine & Upright ( )

Masses No ( ) Yes ( )

Tenderness No ( ) Yes ( )

Discharge No ( ) Yes ( )

Skin changes No ( ) Yes ( )

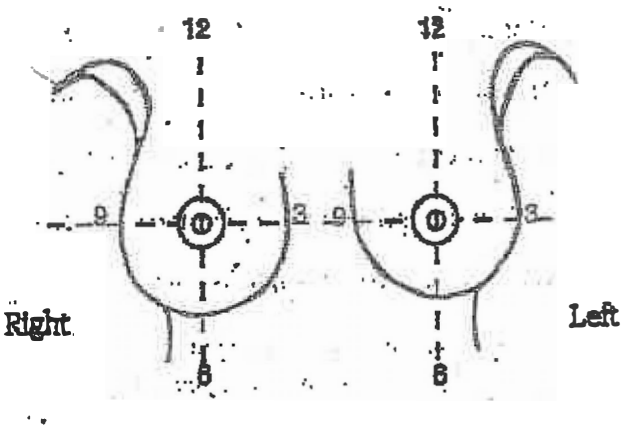
Lymph nodes No ( ) Yes ( )

Last mammo:_____

Chaperone:

_____deferred at pt request

_____ present _____



Abdomen NL ( ) ABNL ( )

Pelvic BUS/Vulva

Vagina

Uterus

Adnexae

Rectal Deferred ( ) NL ( ) ABNL ( )

Guaiac Negative ( ) Positive ( )

ASSESSMENT:

FTFT

PLAN:

( ) Refer to _____

( ) BRCA Assessment

( ) Pap

( ) TBSE

( ) Calcium (mg/day)/vitamin D

( ) Colonoscopy due _____

( ) Exercise min 5x per week

( ) Mammo _____

( ) RTO 1 year AV

( ) DEXA _____

( ) Lipids (FMD)

( ) BC/HRT _____