

Dothan OBGYN

Write your name: _____ **Date:** _____

Patient History

Please complete the following form. Some questions may not apply to you. It is ok not to answer every question.

Mark reason for visit today:

Screening Health Exam and PAP smear (Annual Exam)
Pre-operative appointment
Post-operative appointment
Pregnancy – initial prenatal care appointment
Problem visit or other reason:

Mark Allergies: None

Antibiotics: Penicillin Sulfa
Other: Latex Iodine Shellfish
More:

Medications:

List **medications, dose, and frequency** that you are taking. None

Gynecologic and Obstetric:

Menstrual History:

When did your last menstrual period (LMP) start? Date: _____ **Sure Unsure**
(If unsure, please estimate LMP.)

Are your periods regular? Yes No _____

If regular periods, how frequent in days? (example: every 28 days approximately) _____

Menstruation amount? Mild Moderate Heavy

How many days do your periods last? _____

How old were you when your periods started? _____

Current birth control method: pills condoms sponge diaphragm IUD Norplant Implanon tubal partner
with vasectomy other

List past birth control methods: _____

Dysplasia History:

Total lifetime sexual partners: _____

Age of first sexual intercourse: _____

Are you sexually active? Yes No

Have you had an abnormal pap smear? Yes No _____

How many abnormal pap smears have you had? _____

If yes, please explain . Not Sure

What treatment have you had and when?

Date and result of last PAP smear: _____

Date of last NORMAL PAP smear: same as above, or _____

Pregnancy History:

How many times have you been pregnant? _____

How many miscarriages have you had? _____

How many abortions have you had? _____

How many living children do you have? _____

Comments: _____

Details of pregnancy:

List each of your children's

1) birth order, 2) birth date, 3) number of weeks at birth, 4) sex of each child, 5) birth weight,

6) type of delivery (vaginal or cesarean section) and city:

Did you have Preterm Labor during any pregnancy: Yes No

List your major medical problems: None

List your major surgeries: None

List any major infections: None

Have you had an STD? Yes No _____

Other infections: _____

List any major family genetic diseases: None

Social History:

Marital Status: Single Engaged Married Divorced
Widowed Other _____

Drink Alcohol? _____ Smoke? _____ Illegal / recreational drugs? _____

Highest grade / education level: _____

Are you currently employed? unemployed? retired? other? _____

Current occupation or job: _____

If married, husband's occupation: _____

Family History:

Mother: age _____ Alive Deceased _____

Father: age _____ Alive Deceased _____

Sister(s): _____

Brother(s) _____

Has anyone in your family had the following?

Breast Cancer, Uterine or endometrial cancer, Ovarian Cancer, Colon Cancer

List other known cancers in your family:

Other important family history: _____

Review of Systems:

Mark the following you have had in the **past 30 days**:

General: fever, chills, body aches.

Skin: rashes, masses, bleeding, itching.

Eyes: blurred vision, eye pain, double vision, tearing.

Ears: ear pain, discharge, tinnitus, hearing difficulty.

Nose: nasal congestion/discharge, bleeding, sinus trouble, loss of smell.

Mouth: sore throat, difficulty swallowing, ulcers, sore tongue,
 loss of taste.

Neck: pain, swelling, tenderness, stiffness, masses.

Breast: masses, nipple discharge, tenderness

Respiratory: shortness of breath, cough, wheezing, coughing up blood.

Cardio: chest pains, palpitations (fast heart beat), short of breath

Gastro: abdominal pain, nausea, vomiting, diarrhea, constipation,
 rectal bleeding, vomiting blood.

Genitourinary: discomfort with urination, frequency, urgency, dribbling/leaking, burning,
 retention (unable to urinate).

Musculoskeletal: joint pain, muscle pain, weakness, back pain, twitching, swelling.

Neurological: slurred speech, seizures, localized weakness, headaches, fainting,
 feeling of spinning, tingling in arms or legs

Endocrine: weight change, excessive thirst and urinating, sweating, heat intolerance,

Hem-Immuno: lymph node swelling, easy bleeding and bruising.

Thank you for completing this review.