



OB/GYN Supplement
PG-2002 rev. 04/16

Name: _____ DOB: ____/____/____

Chief Complaint (reason for visit): _____

Method of Birth Control (if applicable): _____

Menstrual Periods First day of Last Menstrual Period: _____ N/A Reason: _____

Do you have regular periods? Yes No Cycle length (days between periods): _____ Length of bleed: _____ days

Bleeding is: Light Moderate Heavy Bleeding between periods? Yes No Pain with period is (0-10): _____

Pregnancy History:

___ Total Pregnancies ___ Term Birth ___ Preterm Birth ___ Miscarriages ___ Multiples ___ Ectopic ___ Abortions ___ Living Children

#	Month/Day/Year	Gender	Weight	Weeks Pregnant	Delivery Type	Anesthesia	Complications/Notes
1							
2							
3							
4							
5							
6							

Pap Smears Date of Last Pap: _____ Was it normal? Yes No

Have you ever had an abnormal Pap? Yes Date: _____ No

If yes, what was the treatment? Colposcopy Cone Biopsy Observation LEEP Cryosurgery

Menopause Symptoms Hot Flashes Irritability Vaginal Dryness Other: _____

Have you had any vaginal bleeding since menopause? Yes No

Are you currently taking hormone replacement therapy? Yes No

Previous hormone replacement therapy? Yes No

Breast Health Date of last mammogram: _____ Never Other Breast Imaging: _____

How often do you perform self-breast exams? Never Monthly Less than Monthly Other: _____

History of breast problems? Yes No Current: Masses/Lumps, Pain, Skin Changes/Redness? Yes No

Colon Health: Date of last colonoscopy: _____

History

Are you currently sexually active? Yes No Recurrent vaginal infections? Yes No

Have you ever had: Chlamydia Gonorrhea Hepatitis Herpes HIV Human Papilloma virus (HPV) Syphilis

Have you had the Human Papillomavirus (HPV) vaccine (i.e. Gardasil)? Yes No

Did you take the full course? Yes No Uncertain Have you ever used fertility medications? Yes No

Please list any medical, surgical, social or family history changes since your last visit: _____

Signature: _____ Date: _____

(Patient or Authorized Representative)

Patient Label

Please check any symptoms you've experienced over the **LAST ONE TO TWO WEEKS:**

<p>General/ Constitution</p> <ul style="list-style-type: none"> <input type="checkbox"/> Activity Change <input type="checkbox"/> Appetite Change <input type="checkbox"/> Chills <input type="checkbox"/> Diaphoresis (Sweating) <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Irritability <input type="checkbox"/> Unexpected Weight Change <p>Ear, Nose & Throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> Congestion <input type="checkbox"/> Dental Problems <input type="checkbox"/> Drooling <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Ear Pain <input type="checkbox"/> Facial Swelling <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Mouth Sores <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Postnasal Drip <input type="checkbox"/> Rhinorrhea (Runny Nose) <input type="checkbox"/> Sinus Pressure <input type="checkbox"/> Sneezing <input type="checkbox"/> Sore Throat <input type="checkbox"/> Tinnitus (Ringing in the Ears) <input type="checkbox"/> Trouble Swallowing <input type="checkbox"/> Voice Change 	<p>Eyes</p> <ul style="list-style-type: none"> <input type="checkbox"/> Eye Discharge <input type="checkbox"/> Eye Itching <input type="checkbox"/> Eye Pain <input type="checkbox"/> Eye Redness <input type="checkbox"/> Photophobia (Sensitivity to Light) <input type="checkbox"/> Visual Disturbance (Blurred Vision) <p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Apnea <input type="checkbox"/> Chest Tightness <input type="checkbox"/> Choking <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Stridor (Airway Obstruction) <input type="checkbox"/> Wheezing <p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Leg Swelling <input type="checkbox"/> Palpitations (Irregular Heart Beat) <p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abdominal Distention (Bloating) <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Anal Bleeding <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal Pain <input type="checkbox"/> Vomiting 	<p>Endocrine</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Polydipsia (Abnormal Thirst) <input type="checkbox"/> Polyphagia (Abnormal Hunger) <input type="checkbox"/> Polyuria (Abnormal Urination) <p>Genitourinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty Urinating <input type="checkbox"/> Dysuria (Painful Urination) <input type="checkbox"/> Enuresis (Involuntary Urination) <input type="checkbox"/> Flank Pain (Low Back Pain) <input type="checkbox"/> Frequency Change (Urinary) <input type="checkbox"/> Genital Sores <input type="checkbox"/> Hematuria (Blood in Urine) <input type="checkbox"/> Menstrual Problems <input type="checkbox"/> Pelvic Pain <input type="checkbox"/> Penile Discharge <input type="checkbox"/> Penile Pain <input type="checkbox"/> Penile Swelling <input type="checkbox"/> Scrotal Swelling <input type="checkbox"/> Testicular Pain <input type="checkbox"/> Urinary Urgency <input type="checkbox"/> Changes in Urine Stream <input type="checkbox"/> Vaginal Bleeding <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Vaginal Pain <p>Musculoskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Arthralgias (Joint Pain) <input type="checkbox"/> Back Pain <input type="checkbox"/> Gait Problems <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Myalgias (Muscle Pain) <input type="checkbox"/> Neck Pain <input type="checkbox"/> Neck Stiffness <p>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Color Change <input type="checkbox"/> Pallor (Paleness) <input type="checkbox"/> Rash <input type="checkbox"/> Wounds 	<p>Allergy/Immunologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Environmental Allergies <input type="checkbox"/> Food Allergies <input type="checkbox"/> Immunocompromised <p>Neurologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dizziness <input type="checkbox"/> Facial Asymmetry <input type="checkbox"/> Headache(s) <input type="checkbox"/> Light Headedness <input type="checkbox"/> Numbness <input type="checkbox"/> Seizures <input type="checkbox"/> Speech Difficulty <input type="checkbox"/> Syncope (Loss of Consciousness) <input type="checkbox"/> Tremors <input type="checkbox"/> Weakness <p>Hematologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Adenopathy (Swollen Glands) <input type="checkbox"/> Bruising Tendency <input type="checkbox"/> Bleeding Tendency <p>Behavioral</p> <ul style="list-style-type: none"> <input type="checkbox"/> Agitation <input type="checkbox"/> Behavioral Problems <input type="checkbox"/> Confusion <input type="checkbox"/> Decreased Concentration <input type="checkbox"/> Dysphoric Mood (Mood Changes) <input type="checkbox"/> Hallucinations <input type="checkbox"/> Hyperactive <input type="checkbox"/> Nervousness <input type="checkbox"/> Anxiety <input type="checkbox"/> Self Injury <input type="checkbox"/> Sleep Disturbance <input type="checkbox"/> Suicidal Thoughts
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Any other symptoms: _____
