GREENBRIER OBSTETRICS AND GYNECOLOGY, P.C.

Gynecological Form

Name:_____ DOB:_____ Age:_____
Race:_____ Marital status: **Never Married / Married / Divorced /Legally Separated / Widowed**
Allergies:_____ Latex Allergy: **YES / NO** Iodine Allergy: **YES / NO**
Medications:_____
Main reason for your visit:_____ Other concerns:_____

*Do you wish to have Gonorrhea/Chlamydia testing? **YES / NO**
*Do you wish to have HIV, Syphilis, and Hepatitis testing? (blood draw) **YES / NO**
*Do you wish to discuss birth control today? **YES / NO** Type:_____

PAST MEDICAL HISTORY

Last Pap Smear:_____ Result:_____ Have you ever had an abnormal pap smear? **YES / NO**
If so, when?_____ Treatment received:_____
Last mammogram:_____ Result:_____ Performed at:_____
Last bone density:_____ Result:_____

Have you ever been diagnosed with (Please circle):

Chlamydia	Genital Herpes	Ectopic Pregnancy	Kidney Problems	Diabetes
Gonorrhea	Genital Warts	Breast Cancer	Bladder Problems	Anemia
PID	HPV	Uterine Cancer	Migraine	Ovarian Cyst
HIV	Uterine Fibroids	Ovarian Cancer	Depression/Anxiety	Asthma
Trichomonas	PCOS	Heart Disease	Bipolar Disorder	Tuberculosis
Hepatitis B	Endometriosis	High Blood Pressure	Osteoporosis	Sickle Cell Trait
Hepatitis C	Uterine Abnormalities	Blood clot in lung/leg	Liver disease	Sickle Cell Disease
Syphilis	Abnormal bleeding	Cystitis	Thyroid disease	Lupus

Other **on-going** medical conditions not listed:_____

MENSTRUAL HISTORY

First day of last menstrual period (LMP):_____ x _____ days Number of days between cycles:_____
Flow amount: **Light / Moderate / Heavy** Age at first menstrual period:_____
Current birth control method:_____ Have you had a tubal ligation? **YES / NO** If so, date:_____
Types of other birth control used in the past: Pills Depo Provera Patch Ring IUD Condoms Vasectomy

PREGNANCY HISTORY

Total number of pregnancies:_____ # of live births:_____ # of losses:_____ # of terminations:_____
# of Vaginal:_____ Dates:_____ # of C-section:_____ Dates:_____

SURGICAL HISTORY

Have you ever had any problems with anesthesia? YES / NO _____

C-Section	Laser surgery	Removal of ovaries	Breast Augmentation	Appendectomy
Colposcopy	D&C	Removal of ovarian cyst	Breast Reduction	Bladder surgery
Cervical biopsy	Hysteroscopy	Uterine ablation	Breast biopsy	Tonsillectomy
LEEP	Laparoscopy	Fibroid embolization	Lumpectomy	Wisdom tooth
Cone biopsy	Hysterectomy	Myomectomy	Mastectomy	Hernia repair
Cryosurgery	Removal of tubes	Tubal ligation	Removal of Gallbladder	Gastric bypass

Other surgeries:_____

SOCIAL HISTORY

Occupation:_____

Do you exercise? **YES / NO**

Have you ever been sexually active? **YES / NO**

Are you currently sexually active? **YES / NO**

Did you have more than one sexual partner in the last year? **YES / NO**

Have you ever smoked cigarettes or tobacco? **YES / NO**

Do you currently smoke? **YES / NO** Amount per day:_____ If former smoker, age quit smoking:_____

Do you use recreational or illicit drugs? **YES / NO** Type:_____

Do you drink alcohol? **YES / NO** Frequency:_____

Have you ever been physically or sexually abused? **YES / NO**

FAMILY HISTORY **(Please list family members diagnosed, if any:)**

Anemia:_____ Heart disease:_____

Twin pregnancy:_____ High cholesterol:_____

Depression:_____ High blood pressure:_____

Diabetes:_____ Tuberculosis:_____

Endometriosis:_____ Psychiatric condition:_____

Menstrual problems:_____ Blood clot in lung or leg:_____

Thyroid disease:_____ Stroke:_____

Kidney disease:_____ Rheumatoid Arthritis:_____

Do you have any family history of any type of cancer? YES / NO If so, please list on the separate sheet provided.

REVIEW OF SYSTEMS: **Please circle *current or on-going* symptoms.**

Cardiovascular/Respiratory
Chest pain
Shortness of breath
Palpitations
Wheezing
Cough
Rheumatic fever
Pneumonia
Bronchitis

Gastrointestinal
Nausea
Vomiting
Abdominal pain
Heartburn
Constipation
Diarrhea
Blood in stool
Peptic ulcer
Food intolerance
Difficulty swallowing
Disorder of Gallbladder

Genitourinary
Pelvic pain
Vaginal discharge
Vaginal itching
Vaginal odor
Painful urination
Frequent urination
Night-time urination
Missed period
Change in periods
Heavy bleeding
Menstrual cramps
Painful intercourse
Decreased desire
Lumps/growths
Genital sores
Bleeding after sex
Blood in urine
Leaking of urine
Kidney stones
Hot flashes
Night sweats
Vaginal dryness

Integumentary
Skin lump/mass
Mole changes
Rashes
Breast lump/mass
Nipple discharge
Breast pain

Neurological
Numbness/Tingling
Headaches
Seizures
Localized weakness
Dizziness
Brain damage

Psychiatric
Anxiety
Depression
Sleep problems
Suicidal thoughts
Anorexia

Endocrine
Excessive appetite
Excessive sweating
Excessive thirst
Heat/Cold intolerance
Hair loss
Excess hair growth

Hematology/Lymphatic
Anemia
Blood transfusion
Swollen glands

Musculoskeletal
Limited joint mobility
Joint pain
Muscle pain
Muscle weakness
Back pain
Difficulty switching position
Hernia of abdomen

Your Signature:_____ Date:_____