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OBYNCWC.COM

Please complete this NEW GYN PATIENT INFORMATION form prior to your visit.

Thank you

DATE _____ NAME _____
 Last First Middle Init

DOB _____ AGE _____ EMAIL _____

PATIENT'S OCCUPATION _____

PRIMARY CARE PHYSICIAN _____

GYN HISTORY

Birth Control:	
• What are you currently using for contraception? _____ How Long? _____	
Periods:	Breast (currently):
<ul style="list-style-type: none"> Date of last menstrual period ___ / ___ / ___ How often do you get your period? _____ Periods last _____ number of days Periods are painful No () Yes () Any medications used: _____ Do the medications relieve your pain? _____ Excessively heavy No () Yes () Heavy Days (# tampons or pads) _____ 	<ul style="list-style-type: none"> Discharge No () Yes () _____ side Lump/s No () Yes () _____ Pain No () Yes () _____ Self Exam No () Yes () _____

FOR WOMEN WHO ARE MENOPAUSAL

Age at menopause _____	Hot Flashes No () Yes ()	Do you take Calcium supplements No () Yes ()
	Insomnia No () Yes ()	
	Night Sweats No () Yes ()	
	Vaginal Dryness No () Yes ()	
Hormone Replacement Therapy No () Yes ()	HRT medications:	Years taken:

ADDITIONAL SYMPTOMS

Abnormal bleeding No () Yes ()	Waking to urinate No () Yes ()
Anxiety No () Yes ()	Sexual dysfunction No () Yes ()
Decreased desire for sex No () Yes ()	Sleep disturbances No () Yes ()
Depression No () Yes ()	Urinary Incontinence No () Yes ()
Difficulty falling asleep No () Yes ()	Urinary urgency No () Yes ()
Painful intercourse No () Yes ()	Vaginal discharge No () Yes ()
History of Infertility No () Yes ()	Vaginal itching No () Yes ()

PLEASE CONTINUE...TURN OVER

(1)

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GYN HISTORY:

		COMMENTS
BREAST DISORDER	No () Yes ()	
ABNORMAL PAP	No () Yes ()	
OVARIAN CYST / MASS	No () Yes ()	
UTERINE FIBROIDS	No () Yes ()	
INFERTILITY TREATMENTS		
GONORRHEA_____ CHLAMYDIA _____	No () Yes ()	
HERPES_____ HPV / GENITAL WARTS_____	No () Yes ()	
HIV_____ SYPHILLIS_____	No () Yes ()	
DOES YOUR PARTNER HAVE A HISTORY OF HERPES	No () Yes ()	

OB / PREGNANCY HISTORY () No Past Pregnancies

DATE	VAGINAL	C-SECTION	ANESTHESIA	WEIGHT OF BABY	LOCATION OF BIRTH	DELIVERING DOCTOR	COMPLICATIONS

MISCARRIAGES, ECTOPIC PREGNANCIES OR TERMINATIONS

DATE	MISCARRIAGE	TERMINATION	ECTOPIC	COMPLICATIONS

MEDICAL HISTORY: Do you currently have or have you been diagnosed with:

BLEEDING / CLOTTING DISORDER	No () Yes ()
HEART DISEASE	No () Yes ()
HYPERTENSION	No () Yes ()
DIABETES	No () Yes ()
THYROID DISEASE / DISORDER	No () Yes ()
LUNG DISEASE (ASTHMA, PNEUMONIA, TB)	No () Yes ()
NEUROLOGICAL DISEASE / DISORDER (STROKE, SEIZURES, MIGRAINES)	No () Yes ()
KIDNEY OR URINARY TRACT	No () Yes ()
GASTROINTESTINAL / LIVER DISEASE	No () Yes ()
VARICOSE VEINS / PHLEBITIS	No () Yes ()
DEPRESSION (INCLUDING POSTPARTUM)	No () Yes ()
PSYCHIATRIC DISORDERS	No () Yes ()
OTHER	No () Yes ()

PAST SURGICAL HISTORY () No Surgical History I need copy of detailed document if you want it included

SURGERY	DIAGNOSIS	YEAR	SURGEON	COMPLICATIONS

Have you ever experienced complications from Anesthesia NO () Yes ()

explain: _____

NAME _____

FAMILY HISTORY (please check the appropriate columns)

	Mother	Father	Sister	Brother	Other	Age onset or death	Comments
ALIVE AND WELL							
DECEASED							
BLEEDING / CLOTTING DISORDER							
CORONARY ARTERY DISEASE /HEART ATTACK							
HYPERTENSION OR STROKE							
DIABETES							
OSTEOPOROSIS							
THYROID DISEASE							
BREAST CANCER							
UTERINE CANCER							
OVARIAN CANCER							
COLON CANCER							
OTHER							

HEALTH MAINTENANCE AND HISTORY

TEST	DATE	NORMAL	ABNORMAL	
LAST PAP TEST				---
MAMMOGRAM				
OSTEOPOROSIS TEST (DEXA OR BONE DENSITY SCAN)				
COLONOSCOPY To be repeated in ____ yrs				

NUTRITION: Calcium supplement No () Yes () Vitamin D No () Yes ()

SOCIAL HISTORY () MARRIED () SINGLE () WIDOW () DIVORCED

- Are you currently sexually active? No () Yes () With a: Man () Woman () Both ()
- How many sexual partners do you currently have? _____ during your lifetime? _____

EXERCISE: TYPE _____ **FREQUENCY** _____

TOBACCO USE: CURRENT: No () Yes () FORMER: No () Yes () NEVER ()
 TYPE _____ PACKS / DAY _____ YEARS SMOKED _____ Passive Smoke Exposure _____

ALCOHOL USE: CURRENT: No () Yes () FORMER: No () Yes () NEVER ()
 AVERAGE DRINKS/WEEK _____ TYPE _____ AMOUNT _____
 YEARS QUIT _____ LAST DRINK _____

CAFFEINE USE: CURRENT: No () Yes () TYPE _____ AMT DAILY _____

HISTORY OF DOMESTIC VIOLENCE (CONFIDENTIAL):
 ARE YOU A VICTIM OR SURVIVOR OF PHYSICAL OR SEXUAL ABUSE No () Yes ()

PLEASE CONTINUE...TURN **OVER**

MEDICATIONS () NO MEDICATIONS (be sure to include over the counter meds and supplements) ... for MD review

NAME (BRAND OR GENERIC)	DOSAGE	HOW OFTEN	START DATE	NAME OF PRESCRIBING PHYSICIAN

ALLERGIES () No Known Allergies

... for MD review

MEDICATION ALLERGY	REACTION
Latex Allergy NO () YES ()	

PHARMACY

NAME	LOCATION / ADDRESS	PHONE NUMBER

Do you want Sexually Transmitted Diseases testing (STDs) ?		No () Yes ()
<p>I request testing for: (please check) _____ Gonorrhea _____ Chlamydia</p>	<p><i>Chlamydia and Gonorrhea</i> are two of the most commonly transmitted STDs in the US.</p> <ul style="list-style-type: none"> • <u>Symptoms</u> can include: Discharge, irregular bleeding, abnormal or pelvic pain, painful intercourse, vague bladder symptoms or they may be "silent" with no symptoms at all. • <u>Testing:</u> a sample is taken from the cervix, similar to a PAP smear. • <u>Cost:</u> ranges fro \$75- \$125, depending on the lab your insurance requires us to use, and MAY or MAY NOT be covered by the insurance 	
<p>I request testing for: (please check) _____ Syphillis _____ Hepatitis B /C _____ HIV</p>	<ul style="list-style-type: none"> • <u>Syphillis, Hepatitis B / C and HIV (Aids Virus)</u> can be tested with a blood sample. • Your insurance MAY or MAY NOT cover the test. 	
Please sign here to authorize this testing:		DATE:

Thank you for taking the time to share this valuable information concerning your health.

Drs. Levitt, Berger-Weiss, Potts, Levenson, Artis, Groves and Allison Ladner, CNM, WHNP