Medical History **Alicia Jones,MD**

Name _____ Birth Date _____ Today's Date _____

Occupation _____ Primary Care Dr. _____ Referred by _____

Please Circle: Single Married Widowed Divorced Separated Spouses Name_____

Date of last: Pap _____ Mammogram _____ Colonoscopy _____

Allergies: Medicine _____ Latex _____ Iodine _____

Problems Today (Please List) _____ Religion (Optional) _____

GYNECOLOGICAL HISTORY

Date of 1st day of your LAST period _____ Age of 1st period _____ Period Length _____

Days between periods _____ Number of pads or tampons used on heaviest day _____

Are you sexually active: Yes Never Previously, not now

What have you used for contraception in the past: Pills Condoms IUD Tubal Nuvaring Depo Shot Nexplanon Other

What do you **currently** use for contraception: Pills Condoms IUD Tubal Vasectomy Nuvaring Depo Shot Nexplanon Partner is same gender Nothing Other

Have you ever: Had an abnormal Pap Smear? Yes No If yes, when _____

Been treated for a sexually transmitted disease? Yes No If yes, when _____ Herpes? Yes No When _____

Do you desire sexually transmitted disease (STD) testing today? Yes No

Have you been a victim of sexual abuse in the past? Yes No If yes, when _____

Do you have other medical problems (ex. High blood pressure, thyroid, depression, anxiety, etc.) Yes No

If yes, what _____

Health Habits:

Do you drink alcohol? Yes No If yes, how much? _____ Do you use tobacco? Yes No If yes, how much? _____

Please list **CURRENT MEDICATIONS** _____

Have you ever been hospitalized or had surgery? Yes No If yes, list year and reason _____

PREGNANCY HISTORY: **Enter number in each**

Full term:____ Preterm: ____ Abortions: ____ Miscarriages: ____ Vaginal Births: ____ C-sections:____ Living Children: ____

Complications: _____

PERSONAL OR FAMILY HISTORY: Please mark if there is a history of the following, who, and what age they were diagnosed:

Breast Cancer: Yes No _____ Ovarian Cancer: Yes No _____

Osteoporosis: Yes No _____ Thyroid Disease: Yes No _____

Uterine Cancer: Yes No _____ Colon Cancer: Yes No _____

Other personal or family diseases: _____

******* FOR OFFICE USE *******

Date_____ **Name**_____ **DOB**_____ **Age**_____ **LMP**_____

Chief Complaint Today: _____

HPI:_____

_____

_____

_____

_____

_____

Review of Systems: Gyn/Sexual ____ Eyes ____ GI____ GU ____ Psych ____ Weight Gain/Loss ____ Neuro____
Endo____ Skin/Breast Changes____

Physical Exam: WT:_____ B/P:_____ HT:_____ BMI:_____ Contraceptives/HRT:_____

normal checked abnormal listed

___GENERAL (normal developed)_____
___NECK (no adenopathy, thyromegaly, mass)_____
___RESP (clear, normal effort)_____
___SKIN (no rash or lesions)_____
___NEURO/PSYCH_____
___LYMPH (normal nodes in neck/groin) _____
___AUSCULTATION (S1 S2 NML w/o murmur)_____
___ABDOMEN (soft/ no masses)_____
___HERNIA_____
___BREAST (NT, w/o mass or discharge)_____
___EXTERNAL (nml size/color)_____
___URETHRAL MEATUS (nml size/color)_____
___BLADDER (NT)_____
___VAGINA (nml discharge & appearance)_____
___CERVIX (nt w/o discharge/lesion)_____
___UTERUS (nt, nml size)_____
___ADNEXA (nt, w/o masses)_____
___ANUS/PERINEUM (w/o lesion/ mass)_____
___RECTAL (nml tone w/o lesion)_____
___ Old Records Reviewed… comments:_____

Reviewed Questionnaire_____
Past Medical History details:_____
_____
_____
Surgical HX:_____
_____
_____
GYN HX:_____
_____
_____
OB HX:_____
_____
_____
FAMILY HX:_____
_____
_____
SOCIAL HX:_____
_____
_____

Tests performed during today's visit: UA_____ HCG_____ Wet Prep_____ GT/CT_____

Review of previous lab results:_____

Assessment/ Plan:_____

_____

_____

_____

_____

Counseling Provided: ____Contraception ____HRT ____Diet/ Exercise ____Self Breast Exam ____Smoking Cessation ____Domestic Violence

Follow up Annual_____ Month(s)_____ Week(s)_____ PRN_____ Per Results_____

PRACTITIONER SIGNATURE:_____ **DATE:**_____