MedStar Health OB/GYN

Room _____

Name: _____ **DOB:** _____ **Date:** _____

Telephone number we should call you at: _____

Reason for visit _____

_____

Pharmacy Name: _____ **Pharmacy Zip Code:** _____ **Phone number**: _____

Vitals Signs: BP:_____/_____ Wt:_____ Ht: _____

1. Have you traveled outside of the country in the past 90 days? ☐ ***YES*** ☐ *NO*

2. On a scale of 0-10 (O = no pain, 10 = severe pain) what is your pain score today? _____

Most recent pap smear date:_____
Last Mammogram date:_____
Last Bone Density date: _____
Last Colonoscopy date:_____

Menstrual History:
When was the first day of your last period? ___/___/___
How long does your period last? _____
How often do you get a period? _____
At what age did you start having periods? _____
Do you have problems with your period? ☐ yes.....☐ no
Do you bleed between periods?..... ☐ yes.....☐ no
Do you bleed after sex?..... ☐ yes.....☐ no
Have you gone through menopause or had your ovaries removed?..... ☐ yes.....☐ no

Contraception:
Are you currently having sex?..... ☐ yes.....☐ no
Are you currently trying to get pregnant? ☐ yes.....☐ no
What method do you use to prevent pregnancy?

☐ Tubal ligation ☐ Vasectomy
☐ Depo Provera ☐ Birth control pills
☐ IUD ☐ Condoms
☐ Diaphragm ☐ Other:_____

Drug Allergies: None ☐ **or**
List:_____

List all Medications/Vitamins/Supplements: **None** ☐

Medication	Dose	Frequency

Lifestyle:
Do you currently smoke?..... ☐ yes.....☐ no
Have you ever smoked?.....☐ yes.....☐ no
Do you drink more than one alcoholic beverage a day?..... ☐ yes.....☐ no
Do you use recreational drugs?..... ☐ yes.....☐ no
What is your occupation?._____
Marital Status?_____
Type of Exercise/Frequency:_____

Family History:

Has anyone in your family ever had (Please ✓ check which one apples)

	Yes	No	If Yes, Who?/Age
Breast Cancer			
Colon Cancer			
Ovarian/Uterine Cancer			
Hypertension			
Heart Disease/ Stroke			
Diabetes			
Prostate Cancer			
Unknown			
Other			

Surgical History: (Please list all surgeries you have had and approximate year Continue on back if needed)
None ☐

Procedure	**Procedure Date**

Pregnancy History:

(Please also include dates for any miscarriage and abortions)

Delivery Date	Weeks at Delivery	Sex	Place of Delivery	Type of Delivery

Medical History: Have you ever had?

Abnormal pap smear?..... ☐ yes.....☐ no
If yes when?_____
Gonorrhea or Chlamydia? ..... ☐ yes.....☐ no
Other sexually transmitted infections?... ☐ yes.....☐ no
If yes please list _____
Cancer? ..... ☐ yes.....☐ no
Diabetes? ..... ☐ yes.....☐ no
Blood clots in your legs or lungs? ..... ☐ yes.....☐ no
Stroke or Heart attack? ..... ☐ yes.....☐ no
High blood pressure? ..... ☐ yes.....☐ no
Depression? ..... ☐ yes.....☐ no
Migraines? ..... ☐ yes.....☐ no
Any other problems for which you see a doctor or take medication? ..... ☐ yes.....☐ no
If yes please list: _____

Do you currently?

Have a breast lump or nipple discharge ☐ yes.....☐ no
Frequently leak urine ..... ☐ yes.....☐ no
Note a bulge from your vagina ..... ☐ yes.....☐ no
Leak stool or gas ..... ☐ yes.....☐ no
Have a partner that abuses or hits you ☐ yes.....☐ no
Feel depressed or anxious..... ☐ yes.....☐ no

MD/MA reviewed: _____ Date: _____

Scanned: _____ Date: _____