

Genesee Valley Obstetrics & Gynecology, P.C.

Name _____ Prefer to be called? _____ Date _____

Reason For Being Seen Today _____

Would you like a Chaperone with you during your exam? Yes No

Primary Care Physician _____ Date of Last Complete Physical Examination _____

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Family History: Are you adopted? Yes No

	Name	Age	Health Problems if Alive	If Deceased Cause of Death
Father				
Mother				
Sisters				
Brothers				

Please Mark a (Y) for Yourself or (F) for Family Member

Diabetes		Clotting/Bleeding Problems	Chicken Pox
High Blood Pressure		Epilepsy	Tuberculosis
Cancer		Birth Defects	Kidney Disease
Heart Disease		Inherited Disease	Hepatitis/Liver Disease
Strokes		Breast Disease	Varicosities/Phlebitis
Thyroid Problems		History of Blood Transfusion	Asthma
Infertility		Autoimmune Disorder	Emotional Illness

Comments: _____

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Medical History: Please Check if You Have or Ever Had the Following

Measles		Difficulty Breathing	Excessive Bleeding w/ Surgery
German (3 day) Measles		Chronic Lung Disease	Migraine Headaches
Mumps		Jaundice	Hearing Problems
Pneumonia		Bowel Problems	Weight Gain/Loss
Rheumatic fever		Change in Bowel Habits	Kidney or Bladder Infection
Chest Pain		Blood in Stool	Involuntary Loss of Urine
X-Rays		Pulmonary Embolus	Pain with Urination
Changes in Facial/Body Hair		Stomach Problems	Frequent Urge to Urinate
Hot Flashes		Genital Herpes/Warts	Pressure with Urination
Other Medical Problems		Gall Bladder Disease	Blood in your Urine

Comments: _____

Previous Surgery/Hospitalizations

Date	Type of Surgery/Hospitalization	Date	Type of Surgery/Hospitalization

Present/Past Illnesses or Problems _____

Medication Allergies: _____

Other Allergies: _____

Medications You Take: _____

- Do you smoke? Yes No How Much? _____ How Long? _____
- Do you drink alcohol? Yes No How Much? _____
- Do you drink caffeine? Yes No How Much? _____
- Do you use marijuana, cocaine or other street drugs? Yes No Explain _____
- Do you exercise? Yes No How Much? _____ What Type? _____
- Do you wear a seat belt? Yes No
- Do you eat a well balanced diet? Yes No
- Do you take Calcium/Vitamin D supplements? Yes No
- Do you see a dentist on a regular basis? Yes No
- Are your immunizations current? Yes No
- Have you had a colonoscopy? Yes No If yes, when? _____
- Have you had a DEXA scan? Yes No If yes, when? _____
- Have you had your cholesterol measured? Yes No If yes, when? _____
- Do you have a Health Care Proxy? Yes No
- Are there any social/family issues that cause worry or concern for you? Yes No
- Do you feel you have experienced physical, emotional, sexual or verbal abuse? Yes No

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Gynecological History:

- Age when periods began _____ First day of last period _____ How often do you have a period _____
- Are you bothered by: Heavy Bleeding Clots Cramping Bloating Mood Changes Irregular Bleeding
- Do you have a history of abnormal pap smears? Yes No
- Have you had a pap smear in the last three years? Yes No If no, when was last pap smear? _____
- Did your mother take DES or any hormone when pregnant with you? Yes No
- Are you having, or have had, intercourse? Yes No If yes, age you became sexually active _____
- Are you sexually active with: Males Females Both
- Are you using birth control? Yes No If Yes, What Method of Birth Control _____
- Are you using condoms? Yes No
- Are you concerned you may have been exposed to any sexually transmitted diseases? Yes No
- Do you have any problems or pain with intercourse? Yes No
- Do you perform self breast exams monthly? Yes No
- Have you ever had a Mammogram? Yes No If yes, When / Where? _____

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Pregnancies:

Any Problems Becoming Pregnant? Yes No If yes, explain _____

List Deliveries:

Date	Type of Delivery	Sex	Birth Weight	Health	Name

Number of living children _____ Any congenital defects? _____

Any complications with pregnancies? _____

Reviewed With Patient _____

