PLEASE PRINT

INITIAL OFFICE VISIT FORM

NAME: Text_____ DATE: _____
DOB: _____AGE_____ REFERRED BY_____

HOW MANY TIMES HAVE YOU BEEN PREGNANT:_____ CHILDREN_____
MISCARRIAGES ___TERMINATIONS___TUBALS/ECTOPICS___HAVE YOU ADOPTED CHILDREN? HOW MANY ___HAVE YOU ADOPTED OUT CHILDREN? HOW MANY___

ARE YOU HERE FOR A ROUTINE ANNUAL EXAM? ____YES ____NO

SPECIFIC ISSUES THAT YOU WANT TO DISCUSS AT THIS VISIT:

_____

_____

_____

WHEN WAS YOUR LAST GYN EXAM: _____LAST PAP SMEAR _____

HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR: ___YES ___NO ___YEAR
IF YES, DID THIS REQUIRE A PROCEDURE? ___YES ___NO

DO YOU STILL GET YOUR PERIOD?
YES ____WHEN WAS YOUR LAST PERIOD _____
NO____ AT WHAT AGE DID THEY STOP? _____

IF YOUR ANSWER IS YES, PLEASE FILL OUT THE QUESTIONS BELOW:

PERIODS BEGAN AT AGE ____AND OCCUR EVERY ____DAYS. THEY LAST APPROX.____DAYS

OB HISTORY: LIST ANY PREGNANCIES:

BY YEAR	VAGINAL/C-SECTION		BABY'S NAME
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____

WHAT KIND OF BIRTH CONTROL ARE YO UUSING? THIS INCLUDES CONDOMS, WITHDRAWAL, TUBAL LIGATION, VASECTOMY, ETC.
_____

DATE OF LAST MAMMOGRAM _____LAST COLONOSCOPY _____
DATE OF LAST BREAST ULTRASOUND _____LAST BONE DENSITY _____

WHO IS YOUR PRIMARY PHYSICIAN _____

WHAT MEDICAL PROBLEMS DO YOU HAVE? THIS INCLUDES HIGH BLOOD PRESSURE, DIABETES, HIGH CHOLESTEROL, UNDERACTIVE THYROID, ETC.
_____
_____
_____
_____

DO YOU HAVE ANY ALLERGIES? IF YES, PLEASE LIST THEM AND YOUR REACTION

_____
_____
_____

WHAT MEDICATIONS ARE YOU ON AND FOR WHAT REASON

_____
_____
_____
_____

HAVE YOU HAD THE GARDASIL VACCINE YES____ NO ____ ***ALL 3 SHOTS*** YES___ NO ___

WHAT SURGERIES HAVE YOU HAD AND WHEN

_____
_____
_____

MARITAL STATUS _____EMPLOYMENT/OCCUPATION _____

DO YOU EXERCISE _____ HOW MANY TIMES PER WEEK _____

DO YOU WEAR SEATBELTS _____

ARE YOU A SMOKER YES ___ NO ___ IF YES, ____ PACKS PER DAY FOR _____ YEARS
FORMER SMOKER YES ___ NO ___

DO YOU DRINK ALCOHOL YES___ NO ___ IF YES, HOW MANY DRINKS PER WEEK ____

DO YOU USE DRUGS YES ___ NO ___ WHAT TYPE _____ HOW OFTEN _____
_____

DO YOU FEEL SAFE AT HOME _____ARE THERE ANY ISSUES YOU WOULD LIKE TO DISCUSS
_____
_____

FAMILY HISTORY:

DOES ANYONE IN YOUR FAMILY HAVE HEART DISEASE, BOWEL, BREAST OR OVARIAN CANCER, HIGH BLOOD PRESSURE, HIGH CHOLESTEROL OR DIABETES? PLEASE LIST EACH RELATIVE AND HOW OLD THEY WERE WHEN THEY WERE DIAGNOSED.

_____

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