PLEASE PRINT

INITIAL OFFICE VISIT FORM

NAME: _____ DATE: _____
DOB: _____AGE_____ REFERRED BY_____

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 PLEASE CIRCLE ANY THAT APPLY:

COLPOSCOPY LEEP CRYOTHERAPY (FREEZING) COLD KNIFE CONIZATION LASER

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

ARE YOUR PERIODS REGULAR OR IRREGULAR?_____
ARE YOUR PERIODS HEAVY AND/OR CRAMPY? _____

OB HISTORY: LIST ANY PREGNANCIES:

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

ARE YOU SEXUALLY ACTIVE? _____ HOW MANY PARTNERS HAVE YOU HAD IN THE PAST YEAR?_____
DO YOU WANT STD TESTING? _____
DO YOU HAVE SEX WITH _____ MALE _____FEMALE_____BOTH

HOW MANY TIMES HAVE YOU BEEN PREGNANT:_____ CHILDREN_____
MISCARRIAGES ___TERMINATIONS___TUBALS/ECTOPICS_____ ADOPTED CHILDREN_____ HAVE YOU ADOPTED OUT CHILDREN? HOW MANY_____

WHAT KIND OF BIRTH CONTROL ARE YOU USING? THIS INCLUDES CONDOMS, WITHDRAWAL, TUBAL LIGATION, VASECTOMY, ETC.

_____

DATE OF LAST MAMMOGRAM _____RESULTS _____
LAST COLONOSCOPY _____RESULTS _____
DATE OF LAST BREAST ULTRASOUND _____RESULTS _____
LAST BONE DENSITY _____ RESULTS_____

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 _____WHAT TYPE OF ACTIVITY_____

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.

_____
_____
_____
_____
_____
_____