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.

_____
_____
_____
_____
_____
_____

Name _____ DOB: _____

Please indicate by circling any of the following symptoms that you are currently experiencing:

CONSTITUTIONAL: Fatigue Fever Chills

EYES AND EARS: Vision changes Hearing difficulty

BREASTS: Lumps Tenderness Nipple discharge

CARDIOVASCULAR: Chest pain Palpitations Fainting Shortness of breath on exertion

RESPIRATORY: Shortness of breath in general

GASTROINTESTINAL: Diarrhea Constipation Loss of appetite Heartburn
Abdominal pain Jaundice Black stools Bloating

GENITOURINARY: Painful urination Bloody urine Incontinence
Painful intercourse Vaginal dryness Hot flashes
Night sweats Vaginal discharge Vaginal odor Kidney disease

SKIN: Rashes Acne Hair Growth

NEUROLOGIC: Tingling or numbness Seizures Sleeping difficulty Headache

MUSCULOSKELETAL: Joint pain Joint swelling

ENDOCRINE: Weight gain Weight loss

PSYCHIATRIC: Anxiety Depression Premenstrual symptoms

HEME/LYMPH: Easy bruising Anemia

ALLERGIC-IMMUNOLOGIC: Sinus allergy symptoms Frequent illnesses

What issues would you like to discuss today?

_____

_____

_____

AUTHORIZATION TO OBTAIN PRESCRIPTION HISTORY

I understand Crescent Street Ob/Gyn may obtain my prescription history from a centralized database to assist in my care, and I authorize Crescent Street Ob/Gyn to do so.

☐ Accept ☐ Decline

Signature _____

DATE _____

Crescent Street OB/GYN
Confidential Communication Request

As required by the Health Insurance Portability and Accountability Act (HIPAA) as amended, you have a right to request communications concerning your personal health information, including appointment reminders, and other healthcare related information, be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests.

I, _____(patient name) hereby request use of confidential channels for communication of information related to personal health, treatment or payment for treatment.

How may we contact you? **Please circle your responses below**

Home Phone Number _____

Do NOT leave message *May leave return number only* *May leave message*

Work Phone Number _____

Do NOT leave message *May leave return number only* *May leave message*

Cell Phone Number _____

Do NOT leave message *May leave return number only* *May leave message*

Text Message Yes No

Email Address(When Available) _____

Do NOT send message *May send return number only* *May relay message*

Authorized persons with whom we may share patient's personal health information:

****This Consent Has NO Expiration unless indicated otherwise in the "Note" area****

Name:_____Relationship_____Note:_____

Name:_____Relationship_____Note:_____

I understand that it is my responsibility to notify the office of any changes to the above listed choices.

Patient Signature:_____**Date:**_____

If this form was not completed by the patient, please sign below and state relationship to patient:

Signature:_____**Date:**_____

Relationship to Patient: Parent Legal guardian Conservator Personal representative