Petoskey Gynecology & Infertility

DATE : _____NAME : _____BIRTHDATE : _____Age:_____

Primary Care Dr._____Date last seen:_____ Referred here by :_____ _____

Reason for this visit : (circle answer**)** **" Yearly "well-woman visit** or **Problem (**What?):_____

Date of Last Menstrual Period :_____ Hysterectomy (removal of uterus)? Yes/ No (please circle answers)
Having intercourse? Yes/ No Do anything to prevent preg? Yes/ No. If yes, what are you doing? (circle answers)
BCPills Patches IUD Condoms Spermicides Tubal Vasectomy Rhythm or withdrawal Other_____

Date of Last: Pap smear _____ History of abnormals? Yes/No If so, when?_____ __ Treartment? _____
Mammogram_____ History of abnormals?_____

Social Status : Married Single Separated Divorced Widow Female partner OCCUPATION : _____

Current MEDICATIONS and dosages (incl. Over the counter and herbal): may attach copy of list 1_____
2_____ 3_____ 4 _____ 5_____

MEDICATION ALLERGIES : 1_____ 2_____ 3 _____ 4_____

Other allergies: _____

SURGERIES : 1_____ 2_____ 3_____ 4 _____5 _____

OTHER HOSPITALIZATIONS: 1_____2_____3_____

CURRENT MEDICAL CONDITIONS (PROBLEMS): 1_____ 2_____ 3_____
(i.e. diabetes, high blood pressure, arthritis) 4_____ 5_____6_____

Problems with Mood Disorders , current or in the past?: depression anxiety irritability other _____

OB History : # of pregnancies ____ # of deliveries _____ Vaginal / C- section Children's ages:_____

WHO IN THE FAMILY HAS (HAD) THESE PROBLEMS: High Blood Pressure?_____
Diabetes?_____ Blood clots (phlebitis)_____ Early stroke or heart attack_____
High Cholesterol_____ Osteoporosis_____

Do you currently SMOKE ? : Yes/ No If yes, _____packs.day.
Have you tried to quit in the past? Yes/ No.
Are you currently trying to quit? Yes/No.
What methods have you used? Meds Patches Counseling Support groups Other_____

Do you drink ALCOHOL ? : Yes/No ____ drinks / day,, _____drinks / week.
Have you been treated for a drinking probem in the past? Yes/No Do you think you might have a problem? Yes/ No
Do you drink CAFFEINE containing drinks ? : Yes / No _____ drinks / day
Have you ever used ILLEGAL DRUGS or abused NARCOTICS ? Yes / No What/when?_____ _____
Have you ever been a victim of DOMESTIC VIOLENCE ? Yes / No When? _____

Do you get regular exercise? Yes/No How many times/week?_____ For how long?_____min.
Do you think you are overweight? Yes/No. If yes, are you following a diet plan in an effort to lose weight? Yes/No
If yes, what do you try and do? _____