

REVIEW OF SYSTEMS HISTORY - PLEASE CHECK (✓) IF ANY OF THE FOLLOWING APPLY TO YOU

GENERAL HEALTH Weight loss or Weight gain <input type="checkbox"/> Fever or Fatigue <input type="checkbox"/>	List Other Signs or Related-Symptoms
CARDIO / PERIPHERAL VASCULAR Painful breathing or Chest pain <input type="checkbox"/> Difficult breathing on exertion <input type="checkbox"/> Swelling of legs <input type="checkbox"/> Palpitations of heart <input type="checkbox"/>	
RESPIRATORY Cough or Wheezing <input type="checkbox"/> Shortness of breath <input type="checkbox"/>	
GASTROINTESTINAL Black or Bloody stool <input type="checkbox"/> Nausea / Vomiting / Diarrhea <input type="checkbox"/> Excessive constipation <input type="checkbox"/>	
GENITAL Irregular periods <input type="checkbox"/> Heavy menstrual flow <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Severe cramping <input type="checkbox"/> Vaginal discharge or odor <input type="checkbox"/> Vaginal pain or itching <input type="checkbox"/> Sores or lesions <input type="checkbox"/> Painful Intercourse <input type="checkbox"/>	
URINARY Blood in urine <input type="checkbox"/> Painful urination <input type="checkbox"/> Urgency or Frequency <input type="checkbox"/> Incomplete emptying <input type="checkbox"/> Leakage of urine (incontinence) <input type="checkbox"/>	
SKIN / BREAST Pain in breast <input type="checkbox"/> Discharge <input type="checkbox"/> Masses / Lumps or Rash / Ulcers <input type="checkbox"/>	
ENDOCRINE Abnormal thirst <input type="checkbox"/> Hot flashes <input type="checkbox"/>	

SOCIAL HISTORY

Marital Status	<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Partner	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
School Completed	<input type="checkbox"/> HS / GED		<input type="checkbox"/> 2/4 Yr College or Tech	<input type="checkbox"/> Graduate Degree	<input type="checkbox"/> Other:	
Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cigarettes Per Day:	Packs Per Day:	# Years:		
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	Drinks Per Week:	Per Day:		
'Street' Drug Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation / Last Job				
Domestic Abuse or Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexual Abuse or Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Expl:		

PAST MEDICAL AND FAMILY HISTORY

PLEASE INDICATE IF YOU OR A RELATIVE - (M)=MOTHER / (F)=FATHER / (S)=SIBLING / (MGP)=MATERNAL GRAND PARENT
(PGP)= PATERNAL GRAND PARENT – WAS AFFECTED BY CONDITION

Condition	You/Age	Relatives/Age	Condition	You/Age	Relatives/Age
Asthma or Respiratory Disease			Heart Dis. or Mitral Valve Prolapse		
Anemia or Bleeding Disorders			Hepatitis		
Blood Clots or Phlebitis			High Blood Pressure		
Cancer – Breast			High Cholesterol		
Cancer – GYN or Ovarian			Stroke or Neurologic Disease		
Cancer – Colon			Thyroid Disease		
Colitis or GI Ulcers			Urinary Infections		
Diabetes			Other _____		

PATIENT GYNECOLOGICAL HISTORY INTAKE

Dear Patient: To better understand your health status, please complete the health survey below.

PERSONAL PAST MEDICAL AND SURGICAL HISTORY

NAME		BIRTH DATE		TODAYS DATE	
Ob / Gyn History		Number		Number	
Number of Times Pregnant				Number of Vaginal Deliveries	
Number of Full Term Deliveries (8 mths+)				Number of Cesarean Deliveries	
Number of Living Children				Describe any Delivery Complications:	
Miscarriages / Abortions / Ectopic Preg.		/ /			
Number of Deliveries Less Than 37 weeks					
Are you using birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Pill [Years on the Pill? _____ Prescptr: _____]			
What birth control method are you using?		<input type="checkbox"/> IUD <input type="checkbox"/> Condom <input type="checkbox"/> Injection/Implant <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Other: _____			
Have you experienced any problems with Birth Control? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:					
About your Periods - Age when started? _____ Number of days: Period Flow? _____ Between Periods? _____					
Are your periods 'regular'? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you experience problems with periods? <input type="checkbox"/> Yes <input type="checkbox"/> No _____					
Prescription & OTC Drugs - Name / Dosage / Frequency			Any Drug or Food Allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known		
			List Drug or Food:		
			Date of Last Test or Immunization		
			Pap Smear:		Pneumonia:
			Mammogram:		Tetanus:
Operations / Hospitalizations – Reason		Date		Operations / Hospitalizations – Reason	
[COVERAGE OF PAP SMEAR + PELVIC EXAM / (1-YEAR) VS. (2-YEARS) [V76.2 / V15.89]					
1. Have you ever been treated for any of the infections listed below? [V13.8] <input type="checkbox"/> No <input type="checkbox"/> Yes (Please 'X' below) <input type="checkbox"/> Vaginosi? <input type="checkbox"/> Genital Warts? <input type="checkbox"/> Chlamydia? <input type="checkbox"/> Herpes? <input type="checkbox"/> Trichonomas? <input type="checkbox"/> Gonorrhea? <input type="checkbox"/> Syphillis?					
2. When was your last Pap Smear?			Month/year /		
3. Have you ever had an 'abnormal' Pap Smear in the past? [795.0]			<input type="checkbox"/> No		<input type="checkbox"/> Yes - What Year? _____
If yes, describe the treatment:					
4. Did you begin sexual activity before you were 16 years old? [V96.2]		<input type="checkbox"/> No		<input type="checkbox"/> Yes	
5. Have you had more than 5 sexual partners in your lifetime? [V69.2]		<input type="checkbox"/> No		<input type="checkbox"/> Yes	
6. Have you ever tested positive for the H.I.V. virus? [V08 or 042]		<input type="checkbox"/> No		<input type="checkbox"/> Yes Date: _____	
7. Did your mother take the drug D.E.S. while pregnant with you? [760.76]		<input type="checkbox"/> No		<input type="checkbox"/> Yes	
Record Completed by: <input type="checkbox"/> Patient - Initials: _____ <input type="checkbox"/> Practice Staff - Initials: _____ <input type="checkbox"/> Provider - Initials: _____					
Record Reviewed by: <input type="checkbox"/> Clinical Staff Initials: _____					
<i>"The Patient's History Was Reviewed And Found To Be Unchanged, Unless Otherwise Documented:"</i>					
<i>Date Reviewed</i>	<i>Provider Signature</i>		<i>Date Reviewed</i>	<i>Provider Signature</i>	

