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

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

SOCIAL HISTORY

Marital Status	☐ Married	☐ Single	☐ Partner	☐ Separated	☐ Divorced	☐ Widowed
School Completed	☐ HS / GED	☐ 2/4 Yr College or Tech		☐ Graduate Degree	☐ Other:	
Smoking	☐ Yes ☐ No	Cigarettes Per Day:		Packs Per Day:	# Years:	
Alcohol	☐ Yes ☐ No	Type:		Drinks Per Week:	Per Day:	
'Street' Drug Use	☐ Yes ☐ No			Occupation / Last Job		
Domestic Abuse or Violence	☐ Yes ☐ No	Sexual Abuse or Violence		☐ Yes ☐ 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 GYNECOLOGIC 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 Then 37 weeks			

Are you using birth control? ☐ Yes ☐ No ☐ Pill [Years on the Pill? _____ Prescptn: _____]

What birth control method are you using? ☐ IUD ☐ Condom ☐ Injection/Implant ☐ Tubal Ligation ☐ Other: _____

Have you experienced any problems with Birth Control? ☐ Yes ☐ No
If yes, please explain:

About your Periods - Age when started? _____ Number of days: Period Flow? _____ Between Periods? _____

Are your periods 'regular'? ☐ Yes ☐ No Have you experience problems with periods? ☐ Yes ☐ No _____

Prescription & OTC Drugs - Name / Dosage / Frequency	*Any Drug or Food Allergies?* ☐ Yes ☐ No ☐ Not Known
	List Drug or Food:
	Date of Last Test or Immunization
	Pap Smear: Pneumonia:
	Mammogram: Tetanus:

Operations / Hospitalizations – Reason	*Date*	*Operations / Hospitalizations – Reason*	*Date*

[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]	☐ No	☐ Yes (Please 'X' below)
☐ Vaginosis? ☐ Genital Warts? ☐ Chlamydia? ☐ Herpes? ☐ Trichonomas? ☐ Gonorrhea? ☐ Syphillis?		
2. When was your last Pap Smear? Month/year	/	
3. Have you ever had an 'abnormal' Pap Smear in the past? [795.0]	☐ No	☐ Yes - What Year? _____
If yes, describe the treatment:		
4. Did you begin sexual activity before you were 16 years old? [V96.2]	☐ No	☐ Yes
5. Have you had more than 5 sexual partners in your lifetime? [V69.2]	☐ No	☐ Yes
6. Have you ever tested positive for the H.I.V. virus? [V08 or 042]	☐ No	☐ Yes Date: _____
7. Did your mother take the drug D.E.S. while pregnant with you? [760.76]	☐ No	☐ Yes

Record Completed by: ☐ Patient - Initials:_____ ☐ Practice Staff - Initials: ☐ Provider - Initials:_____

Record Reviewed by: ☐ Clinical Staff Initials: _____

"The Patient's History Was Reviewed And Found To Be Unchanged, Unless Otherwise Documented:"

Date Reviewed	*Provider Signature*	*Date Reviewed*	*Provider Signature*