PATIENT'S SELF HISTORY

Date______________________

Name________________________________ Phone Number________________________

DOB___________________ Height________ Weight__________ Date of last menstrual period___________

What is the problem/concern that brings you to our office today?_____________________________________

____

How did you hear about Lawrence OB-GYN Specialists?____

PAIN: YES NO If yes, please describe location and description_______________________________

____

Allergies____

PRESCRIPTION MEDICATIONS	DOSE	OVER THE COUNTER MEDICATIONS	DOSE

Vitamins/Supplements____

Insurance____________________________________ Pharmacy of Choice_____________________________

Primary Care Physician________________________

Have you had a Pap Smear? YES NO Date:_______________ Result:_________________

Have you had a Mammogram? YES NO Date:_______________ Result:_________________

Have you had a Bone Density Scan? YES NO Date:_______________ Result:_________________

Have you had a Colonoscopy? YES NO Date:_______________ Result:_________________

Have you received the Gardasil Vaccine? YES NO

Have you received the Whooping Cough Vaccine? YES NO

Social History:

1. Tobacco: YES NO PAST Current-how much:_________ Ready to change? YES NO
2. Alcohol: YES NO PAST Current-how much:_________ Ready to change? YES NO
3. Illegal substance: YES NO PAST Current-how much:_________ Ready to change? YES NO
4. Exercise: YES NO How Often_____________ What type__________________________
5. Employment/Occupation___________________________
6. Religious restrictions regarding health care____
7. Sexually Active: YES NO Men/Women #of lifetime partners_______ #of current partners_________
   Current Contraceptive Method:___________________________ Condom Use? YES NO
8. Sexual Abuse: PAST CURRENT NONE
9. Verbal Abuse: PAST CURRENT NONE
10. Physical Abuse: PAST CURRENT NONE
11. Nutrition/Diet: Regular Calorie Restricted Vegetarian Diabetic Other:_____________

Self Past Medical History: (Please Circle)

Aids Exposure
Anorexia/Bulimia
Asthma
Blood Clot
Blood Disorder
Cancer (type)____________
Depression/Anxiety
Diabetes
Emphysema
Endometriosis
Epilepsy/Seizures
Heart Disease
High Blood Pressure
High Cholesterol
History of Abnormal Pap
Immune Compromise
Infertility
Kidney/Liver Disease
Migraines
Osteopenia/Osteoporosis
Psychiatric Disorder
Std History
Thyroid Disease
Tuberculosis
UTI Problems
Varicosities/Phlebitis

Procedure/Surgical History:	Date of Last Procedure/Surgery	Results

Family History	Relationship	Age Diagnosed
Bleeding Disorder		
Blood Clots		
Diabetes		
Heart Disease		
Cancer		
High Cholesterol		
Kidney/Liver Disease		
Osteopenia/Osteoporosis		
Tuberculosis		
Thyroid Disease		

OB History **(Indicate mode of Delivery)**

Date	Sex	Birth Weight	Weeks Gestation	Vaginal	C-Section	Miscarriage	Abortion	Still-Born

Has Menses Started? YES NO *If yes, please answer questions below:*

Started at Age:______________
Frequency (in days):__________
Duration (in days):____________
Pads/Tampons per day:________

Postmenopausal? YES NO
Hysterectomy? YES NO

Genitourinary Symptoms: (Please Circle)

NO CONCERNS
Dysuria (Painful)
Hematuria (Blood)
Incontinence (Leaking)
Nocturia (Nightime)
Oliguria (Minimal Void)
Polyuria (Excessive Void)
Urinary Dribbling
Urinary Frequency
Urinary Hesitation
Urinary Retention
Urinary Urgency
Vaginal Discharge

GYN Symptoms: (Please Circle)

NO CONCERNS
Abnormal Discharge
Pain with Intercourse
Itching/Burning External
Itching/Burning Internal
Sexual Dysfunction
Breast Pain? Right Left Both
Hot Flashes
Irregular Menses

Constitutional: (Circle) No Concerns Weight Loss Weight Gain Fever Fatigue Chills Sweats
Other Symptoms____