Stanford HEALTH CARE

New OB-Gyn Patient

Preferred Name:_____ **Age:** _____ **Referred by:**_____
Last period: _____ Regular Irregular Menopause Hysterectomy Ablation IUD Birth Control pills
Reason for today's visit: ☐ Preventative Care ☐ Problem Visit
Please explain:

Please answer the following questions to the best of your ability.
Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than ½ the Days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

3. Are you currently in a relationship where your partner makes you feel unsafe? ☐ Yes ☐ No
4. In the past, have you experienced physical or emotional abuse? ☐ Yes ☐ No

Drug Allergies ☐ None ☐ Yes, List with reaction:_____
Latex Allergy ☐ Yes ☐ No
Current Medications: (circle if refill needed)_____

_____

Review of symptoms: Check any of the following that you are **currently experiencing** ☐ **NONE**

General:	☐ Extreme Fatigue	☐ Depression	☐ Fever	
	☐ Weight gain ____ lbs	☐ Weight loss____ lbs	☐ Cold intolerance	☐ Heat intolerance
Skin:	☐ Rash	☐ Change in mole		
Respiratory/ Cardiac:	☐ Shortness of breath	☐ Cough	☐ Chest pain	☐ Palpitations
Breast:	☐ Lump	☐ Pain	☐ Redness	☐ Nipple discharge
Gastrointestinal:	☐ Abdominal pain	☐ Black or bloody stools	☐ Bloating	☐ Diarrhea
	☐ Constipation	☐ Nausea	☐ Vomiting	☐ Change in bowel movements
Gynecologic:	☐ Abnormal bleeding	☐ Pain during sex	☐ Vulvar lump	☐ Painful cramps
	☐ PMS Symptoms_____			☐ Genital herpes
	☐ Menopausal symptoms_____			☐ Genital warts / HPV
	☐ Vaginal discharge			
Urinary:	☐ Loss of urine	☐ Pain with urination	☐ Urinary frequency	☐ Urgency
Musculoskeletal:	☐ Muscle aches	☐ Muscle weakness		
Neurologic:	☐ Change in headaches	☐ Numbness	☐ Dizziness	

Sexually Active: ☐ Yes ☐ No ☐ Not currently **Partner:** ☐ Male ☐ Female ☐ Both
Occupation:_____ Relationship Status: _____ Partner's Name:_____

Contraception or Birth Control: ☐ N/A

☐ Abstinence	☐ Withdrawal	☐ Condom	☐ Diaphragm	☐ Foam	☐ Spermicide	☐ Sponge
☐ Pill	☐ Ring	☐ Depo-Provera	☐ Patch			
☐ Nexplanon (inserted_____)		☐ IUD Type:_____ (inserted_____)			☐ Tubal Ligation	☐ Vasectomy

For Nursing and Doctors: Height_____ Weight _____ BP _____
Orders: ☐ Pap smear ☐ Mammogram ☐ Labs ☐ DXA ☐ STI ☐ GC/CT ☐ Immunizations_____

Gynecologic History:

Age periods began:_____ Length of period (days):_____ Number of days between periods:_____

Do you have menstrual cramps? ☐ Yes ☐ No History of STD's? ☐ Yes ☐ No Type?_____

Do you have any gynecologic problems?_____

Screening tests: Please write when it was last performed

Pap smear:_____ ☐ N/A Was it normal? ☐ Yes ☐ No Where? _____

Have you ever had an abnormal Pap test? ☐ Yes ☐ No Treatment: Colposcopy / Cryotherapy / LEEP / Cone Biopsy

Colonoscopy:_____ ☐ N/A Was it normal? ☐ Yes ☐ No Where? _____

Mammogram: _____ ☐ N/A Was it normal? ☐ Yes ☐ No Where? _____

Do you do regular breast self-examinations? ☐ Yes ☐ No

Bone Density:_____ ☐ N/A Was it normal? ☐ Yes ☐ No Where? _____

Medical Conditions: Check all that apply in the past or presently

☐ Alcohol Abuse
☐ Alzheimer's
☐ Anemia
☐ Anxiety
☐ Aortic Stenosis
☐ Arthritis
☐ Asthma
☐ Atrial fibrillation
☐ Birth Defects
☐ Cancer_____
☐ Chronic Obstructive Pulmonary Disease
☐ Congestive heart failure
☐ Coronary artery disease
☐ Dementia
☐ Depression
☐ Diabetes (treated with diet / pills / insulin)
☐ Endometriosis
☐ Fecal Incontinence
☐ Genital Herpes
☐ Hepatitis B or Hepatitis C
☐ Hypertension (high blood pressure)
☐ Hyperlipidemia (high cholesterol)
☐ Hyperthyroid (High thyroid)
☐ Hypothyroid (Low thyroid)
☐ Infertility
☐ Irritable Bowel Syndrome
☐ Leukemia
☐ Myocardial Infarction (Heart attack)
☐ Obesity
☐ Obstructive Sleep Apnea
☐ Osteoporosis
☐ Polycystic Ovary Syndrome (PCOS)
☐ Pulmonary Embolism (or blood clot)
☐ Recurrent Bladder Infections
☐ Renal Insufficiency or Kidney Problems
☐ Seizure Disorder
☐ Stroke
☐ Tuberculosis
☐ Ulcers or H pylori
☐ Urinary incontinence

☐ Other:_____

Surgical History: please add approximate year

☐ Abdominal Surgery Year:_____
☐ Appendectomy Year:_____
☐ Breast Biopsy Year:_____
☐ Breast Implants Year:_____
☐ Cardiac Catheterization Year:_____
☐ Colonoscopy (polyp?) Year:_____
☐ C-Section Year:_____
☐ D&C for bleeding Year:_____
☐ Gall bladder surgery Year:_____
☐ Gastric bypass Year:_____
☐ Heart surgery (CABG) Year:_____
☐ Hernia Repair Year:_____
☐ Hysterectomy Year:_____
☐ Laparoscopy Year:_____
☐ LEEP / cone biopsy Year:_____
☐ Miscarriage (D&C) Year:_____
☐ Myomectomy Year:_____
☐ Tonsillectomy Year:_____
☐ Tubal Ligation Year:_____
☐ Tummy tuck Year:_____
☐ Uterine Ablation Year:_____

☐ Other surgery:_____

Social History:

Tobacco Use: ☐ Never smoked ☐ Current Smoker ☐ Smokeless Tobacco ☐ Former Smoker
Ready to quit? ☐ Yes ☐ No

Packs of cigarettes each day:_____ Number of years smoked?_____

E-cigarettes: ☐ Never smoked ☐ Current Smoker ☐ Former Smoker Ready to quit? ☐ Yes ☐ No

Alcohol use: Do you drink alcohol? ☐ Yes ☐ No If yes, Drinks each week: _____

Recreational drug use: ☐ Yes ☐ No

Type: ☐ Marijuana ☐ Methamphetamine ☐ Ectasy ☐ Cocaine ☐ Heroin ☐ Prescription Drug

Family History: Please list any medical problems that your family has had. ☐ **N/A (Adopted)**

Mother: _____

Father: _____

Sister: _____

Sister: _____

Brother: _____

Brother: _____

Relative - include grandparents, aunts, uncles and list maternal or paternal.

Other: _____

Pregnancy History:

Total number of pregnancies: _____ Total living children: _____

Number of deliveries after 36 weeks (full term): _____ Vaginal: _____ Cesarean: _____

Number of deliveries before 36 weeks (perterm): _____ Vaginal: _____ Cesarean: _____

Number of miscarriages: _____ Number of terminations: _____ Number of ectopic pregnancies: _____

Vaccinations: Please document dates given, if requesting Vaccinations today please circle

Flu shot: (recommended yearly) _____

TdaP - Tetanus, Diphtheria, and Pertussis or whooping cough (recommended every 10 yrs) _____

Shingles or Shingrix: (recommended after age 50) _____

Pneumococcal: (recommended after age 60 OR younger with risk factors) _____

Gardasil: (HPV Immunization - 3 dose series) _____

Health Screening:

Hepatitis C blood test (one time testing for those born 1945-1965) _____

Have you had recent blood work? Who has the results? _____

What other doctors do you have: _____

_____

These questions cover important gynecological issues for all women. We strongly encourage everyone to have a Primary Care Physician to cover other health issues.

Please register for chart access at https://myhealth.stanfordhealthcare.org