

**OB/GYN ASSOCIATES OF ALABAMA, P.C.**

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Are you here for an Annual Exam or a Problem? (Please circle one)

If you are having a problem, please explain, including how severe it is and how long it has lasted: \_\_\_\_\_

**GYNECOLOGICAL HISTORY**

Date of your last Menstrual period \_\_\_\_\_ Date of your last pap smear \_\_\_\_\_  
 How many days do you bleed? \_\_\_\_\_ Have you ever had an abnormal pap smear? \_\_\_\_\_  
 Number of days between your periods \_\_\_\_\_ If yes, when? \_\_\_\_\_  
 Cramping is, mild, moderate, severe (circle one) \_\_\_\_\_ Date of your last mammogram \_\_\_\_\_  
 Are you sexually active? \_\_\_\_\_ Have you ever had an abnormal mammo? \_\_\_\_\_  
 Birth Control: now \_\_\_\_\_ past \_\_\_\_\_ (pill, IUD, etc) If yes, when? \_\_\_\_\_

**OBSTETRIC HISTORY**

		Number			Number			Number
Pregnancies			Abortions			Miscarriages		
Premature Births: (<37 weeks)			Live Births			Living Children		
No.	Birth Date	Weight at birth	Baby's Sex	Weeks Pregnant	Type of Delivery (Vaginal, Cesarean, Etc.)	Complications?		
1.								
2.								
3.								
4.								
5.								

**OPERATIONS / HOSPITALIZATIONS**

Reason	Date	Hospital

**CURRENT MEDICATIONS**

(Including hormones, vitamins, herbs, nonprescription medications)

Drug Name	Dosage	Who Prescribed	Drug Name	Dosage	Who Prescribed

PLEASE LIST ANY DRUG ALLERGIES: \_\_\_\_\_

**PERSONAL PROFILE**

Sexual Orientation  Heterosexual  Homosexual  Bisexual  
 Marital Status  Married  Single  Living with Partner  Widowed  Divorced  
 School Completed  High School  College  Graduate Degree  Other \_\_\_\_\_  
 Current or most recent job \_\_\_\_\_  
 Do you smoke? \_\_\_\_\_ Packs per day \_\_\_\_\_ Alcohol  Yes  No Drinks per day \_\_\_\_\_ Drinks per week \_\_\_\_\_  
 Drug use? \_\_\_\_\_  
 Regular Exercise? \_\_\_\_\_ How often? \_\_\_\_\_  
 Other Pertinent Personal Info \_\_\_\_\_

## PAST MEDICAL / FAMILY HISTORY

Mother:  Living  Deceased - Cause:

Age:

Father:  Living  Deceased - Cause:

Age:

Age:

In the following section please mark all illnesses that apply to you and / or your family members, now or in the past. If you mark an illness for a family member please indicate which relative and age of onset. (Some illnesses are not applicable for family members.)

Illness	You	Family	Relative(s) / age of onset	Illness	You	Family	Relative(s) / age of onset
Osteoporosis (weak bones)	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis	<input type="checkbox"/>	NA	
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Back Problems	<input type="checkbox"/>	NA	
Cervical Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Lupus	<input type="checkbox"/>	<input type="checkbox"/>	
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Seizures/Convulsions/Epilepsy	<input type="checkbox"/>	NA	
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Depression/Anxiety	<input type="checkbox"/>	NA	
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>		Eating Disorder	<input type="checkbox"/>	NA	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Psychiatric Disorders	<input type="checkbox"/>	NA	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	NA	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>		Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel Problems	<input type="checkbox"/>	NA		Tuberculosis	<input type="checkbox"/>	NA	
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>		Kidney Stones	<input type="checkbox"/>	NA	
Reflux	<input type="checkbox"/>	NA		Hepatitis	<input type="checkbox"/>	NA	
Ulcers	<input type="checkbox"/>	NA		HIV/AIDS	<input type="checkbox"/>	NA	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatic Fever	<input type="checkbox"/>	NA	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>		Sexually Transmitted Disease	<input type="checkbox"/>	NA	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>		Genetic Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Clots in Lungs or Legs	<input type="checkbox"/>	<input type="checkbox"/>		Other	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Transfusion	<input type="checkbox"/>	NA					

## REVIEW OF SYSTEMS

Please check (x) if any of the following symptoms apply to you now

<p><b>1. Eyes</b></p> <input type="checkbox"/> Double Vision <input type="checkbox"/> Spots before Eyes <input type="checkbox"/> Vision Changes	<p><b>6. Genitourinary Continued</b></p> <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Fibroids <input type="checkbox"/> Infertility <input type="checkbox"/> DES Exposure <input type="checkbox"/> Abnormal Vaginal Discharge
<p><b>2. Ear, Nose, and Throat</b></p> <input type="checkbox"/> Earaches <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Sore Throat <input type="checkbox"/> Mouth Sores	<p><b>7. Musculoskeletal</b></p> <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Muscle or Joint Pain
<p><b>3. Cardiovascular</b></p> <input type="checkbox"/> Painful Breathing <input type="checkbox"/> Chest Pain or Pressure <input type="checkbox"/> Difficulty Breathing on Exertion <input type="checkbox"/> Swelling of Legs	<p><b>8a. Skin</b></p> <input type="checkbox"/> Rash <input type="checkbox"/> Sores <input type="checkbox"/> Changes in Moles
<p><b>4. Respiratory</b></p> <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Chronic Cough	<p><b>8b. Breasts</b></p> <input type="checkbox"/> Pain in Breast <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Lumps
<p><b>5. Gastrointestinal</b></p> <input type="checkbox"/> Frequent Diarrhea <input type="checkbox"/> Bloody Stool <input type="checkbox"/> Nausea/Vomiting/Indigestion <input type="checkbox"/> Constipation <input type="checkbox"/> Involuntary loss of gas or stool	<p><b>9. Neurologic</b></p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Severe Memory Problems <input type="checkbox"/> Frequent or Severe Headaches
<p><b>6. Genitourinary</b></p> <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Pain with Urination <input type="checkbox"/> Strong Urgency to Urinate <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Incomplete Emptying <input type="checkbox"/> Involuntary/Unintended Urine Loss <input type="checkbox"/> Urine Loss when Coughing or Lifting <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> Painful Periods <input type="checkbox"/> Premenstrual Syndrome (PMS)	<p><b>10. Psychiatric</b></p> <input type="checkbox"/> Depression or Frequent Crying <input type="checkbox"/> Severe Anxiety
	<p><b>11. Endocrine</b></p> <input type="checkbox"/> Hair Loss <input type="checkbox"/> Heat/Cold Intolerance <input type="checkbox"/> Abnormal Thirst <input type="checkbox"/> Hot Flashes
	<p><b>12. Hematologic/Lymphatic</b></p> <input type="checkbox"/> Frequent Bruises <input type="checkbox"/> Easy bleeding
	<p><b>13. Constitutional</b></p> <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain