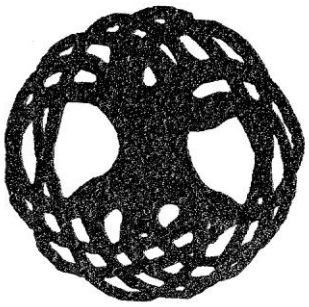

Ashley Oaks OB/GYN
Kathryn M. Hargrove, M.D.

NAME _____ AGE _____ DATE _____

PLACE OF EMPLOYMENT _____

OCCUPATION _____
PROBLEMS AND/OR REASON FOR VISIT

GYN SYSTEM REVIEW

MENSES: AGE AT ONSET OF PERIOD_____ DATE OF LAST PERIOD _____
ARE YOUR PERIODS REGULAR ☐ **YES** ☐ **NO**
HOW OFTEN ARE THEY _____ HOW LONG DO THEY LAST _____
NUMBER OF PADS USED ON HEAVIEST DAYS _____ DATE OF LAST PAP _____
DO YOU HAVE BLEEDING AFTER INTERCOURSE ☐ **YES** ☐ **NO**
DO YOU HAVE SIGNIFICANT PAIN WITH YOUR PERIOD ☐ **YES** ☐ **NO**
DO YOU TAKE PAIN MEDICATION ☐ **YES** ☐ **NO**
IF YES, WHAT DO YOU TAKE_____
DO YOU MISS WORK MONTHLY ☐ **YES** ☐ **NO**
DO YOU HAVE A CHRONIC OR PERSISTENT DISCHARGE ☐**YES** ☐ **NO**

CIRCLE APPLICABLE ONE (S) DO YOU… ITCH BURN HAVE AN ODOR

HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR ☐ **YES** ☐ **NO**

IF SO, WHEN_____

BIRTH CONTROL METHODS

WHAT ARE YOU USING NOW FOR BIRTH CONTROL _____

IF YOU ARE USING BIRTH CONTROL PILLS, WHAT BRAND _____

WHAT TYPE OF BIRTH CONTROL HAVE YOU USED IN THE PAST

(INCLUDE CONDOMS, BTL, ETC.)_____

DO YOU HAVE PAIN WITH INTERCOURSE ☐ **YES** ☐ **NO**
DO YOU HAVE PROBLEMS WITH SEXUAL FUNCTIONS ☐ **YES** ☐ **NO**

BREAST INFORMATION

HAVE YOU HAD ANY MASSES OR LUMPS ☐ **YES** ☐ **NO**
DO YOU HAVE A BREAST DISCHARGE ☐ **YES** ☐ **NO**
HAVE YOU HAD A MAMMOGRAM ☐ **YES** ☐ **NO**

IF YES, WHEN WAS YOUR LAST ONE _____

DELIVERIES

DATE	WEIGHT GAIN	LENGTH OF LABOR	TYPE OF ANESTHESIA	TYPE OF DELIVERY	INFANT SEX / WEIGHT	WEEKS PREGNANT AT DELIVERY	PROBLEMS WITH PREGNANCY

MISCARRIAGE(S)/ABORTION(S)

DATES	LENGTH OF PREGNANCY	COMPLICATIONS	LOCATION

GU SYSTEM REVIEW

DO YOU HAVE OR HAVE YOU HAD BURNING DURING URINATION ☐ **YES** ☐ **NO**

DO YOU WET YOURSELF INVOLUNTARILY WITH ANY OF THE FOLLOWING:

(CIRCLE ALL APPLICABLE) COUGHING LAUGHING SNEEZING

RUNNING LIFTING GOING UP/DOWN STAIRS

CIRCLE ONE OF THE FOLLOWING: ARE THEY WEAK OR HEAVY STREAMS

DO YOU HAVE FREQUENT BLADDER OR KIDNEY INFECTIONS ☐ **YES** ☐ **NO**
HAVE YOU SEEN A UROLOGIST ☐ **YES** ☐ **NO**
HAVE YOU EVER HAD KIDNEY STONES ☐ **YES** ☐ **NO**
HAVE YOU HAD KIDNEY X-RAYS ☐ **YES** ☐ **NO**

GI SYSTEM REVIEW

HAVE YOU HAD ANY RECENT WEIGHT CHANGES ☐ **YES** ☐ **NO**
IF YES, HOW MUCH _____WHEN_____
HAVE YOU HAD ANY CHANGES IN BOWEL HABITS ☐ **YES** ☐ **NO**
DO YOU TAKE LAXATIVES ☐ **YES** ☐ **NO**
IF YES, HOW OFTEN DO YOU TAKE THEM _____
DO YOU HAVE BLOOD IN YOUR STOOLS ☐ **YES** ☐ **NO**
DO YOU HAVE FREQUENT/CHRONIC DIARRHEA ☐ **YES** ☐ **NO**
DO YOU HAVE ULCERS ☐ **YES** ☐ **NO**
DO YOU HAVE GALL BLADDER DISEASE ☐ **YES** ☐ **NO**
DO YOU HAVE INTESTINAL/STOMACH DISORDERS ☐ **YES** ☐ **NO**
DO YOU HAVE FREQUENT/CHRONIC NAUSEA/VOMITTING ☐ **YES** ☐ **NO**

ALLERGIES

HAVE YOU EVER TAKEN PENICILLIN ☐ **YES** ☐ **NO**
ARE YOU ALLERGIC TO ANY DRUGS/MEDICATIONS ☐ **YES** ☐ **NO**

DRUG	REACTION

GENERAL HEALTH INFORMATION

DO YOU SMOKE OR HAVE YOU EVER SMOKED ☐ **YES** ☐ **NO**
IF YES, HOW MANY PACKS PER DAY _____
DO YOU DRINK REGULARY OR DID YOU EVER DRINK ☐ **YES** ☐ **NO**
IF YES, HOW OFTEN/HOW MUCH _____
DO YOU TAKE ANY OTHER DRUGS ON A REGULAR BASIS
OR FOR RECREATION ☐ **YES** ☐ **NO**
IF YES, WHAT _____

SURGERIES AND/OR HOSPITALIZATIONS

DATE	HOSPITAL	REASON	PHYSICIAN

PAST MEDICAL HISTORY

(IF YES, INDICATE DATES, TREATMENT AND BY WHOM)

ASTHMA ☐**YES** ☐ **NO** _____
HIGH BLOOD PRESSURE ☐ **YES** ☐ **NO**_____
DIABETES ☐ **YES** ☐ **NO**_____
HEPATITIS/JAUNDICE ☐ **YES** ☐ **NO**_____
PHLEBITIS ☐ **YES** ☐ **NO**_____
MIGRAINE HEADACHES ☐ **YES** ☐ **NO**_____
DEPRESSION ☐ **YES** ☐ **NO**_____
LUNG PROBLEMS ☐ **YES** ☐ **NO**_____
HEART DISEASE ☐ **YES** ☐ **NO**_____
CHRONIC KIDNEY DISEASE ☐ **YES** ☐ **NO**_____
THYROID DISEASE ☐ **YES** ☐ **NO**_____
EPILEPSY ☐ **YES** ☐ **NO**_____

PAST MEDICAL HISTORY (CONTINUED)

PSYCHIATRIC ILLNESS ☐ **YES** ☐ **NO**_____

BLEEDING TENDENCIES ☐ **YES** ☐ **NO**_____

HAVE YOU OR YOUR PARTNER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:
(IF YES, PLEASE LIST DATE AND PHYSICIAN CONSULTED)

HERPES ☐ **YES** ☐ **NO**_____

GENITAL WARTS ☐ **YES** ☐ **NO**_____

AIDS ☐ **YES** ☐ **NO**_____

SYPHILIS ☐ **YES** ☐ **NO**_____

GONORRHEA ☐ **YES** ☐ **NO**_____

CHLAMYDIA ☐ **YES** ☐ **NO**_____

HAVE YOU EVER HAD A TRANSFUSION ☐ **YES** ☐ **NO**

FAMILY HISTORY

	AGE	STATE OF HEALTH	SPECIFIC MEDICAL PROBLEMS	DEATH CAUSE	AGE AT TIME OF DEATH
MOTHER					
FATHER					
BROTHER					
BROTHER					
SISTER					
SISTER					

HAS ANY OF THE FOLLOWING BEEN DIAGNOSED IN ANY RELATIVES AND IF SO PLEASE SPECIFY THE RELATIONSHIP (AUNT, UNCLE, GRANDPARENT, ETC.)

BREAST CANCER ☐ **YES** ☐ **NO**_____
OTHER CANCERS ☐ **YES** ☐ **NO**_____
DIABETES ☐ **YES** ☐ **NO**_____
HIGH BLOOD PRESSURE ☐ **YES** ☐ **NO**_____
HEART DISEASE/STROKE ☐ **YES** ☐ **NO**_____
THYROID/LUPUS ☐ **YES** ☐ **NO**_____
EMOTIONAL/DEPRESSION ☐ **YES** ☐ **NO**_____
EMPHYSEMA/ASTHMA ☐ **YES** ☐ **NO**_____
GYNECOLOGICAL(FEMALE) PROBLEMS ☐ **YES** ☐ **NO**_____
HEPATITUS/JAUNDICE ☐ **YES** ☐ **NO**_____
BLEEDING/CLOTTING PROBLEMS ☐ **YES** ☐ **NO**_____

FAMILY HISTORY (CONTINUED)

OTHER MEDICAL PROBLEMS TYPE_____ WHOM_____

ARE THERE ANY BIRTH DEFECTS IN YOU OR YOUR SPOUSE'S FAMILY ☐ YES ☐ NO

TYPE_____ WHOM_____

ARE THERE ANY MULTIPLE BIRTHS IN YOU OR YOUR SPOUSE'S FAMILY ☐ YES ☐ NO

TYPE_____ WHOM_____

IF THERE IS ANY OTHER PERTINENT MEDICAL INFORMATION NOT PREVIOUSLY MENTIONED ABOVE, PLEASE LIST BELOW

_____

_____

_____

_____

_____

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