GYNECOLOGY – O'Connor Medical Clinic

What is the reason for your visit?

1)

2)

What medications are you taking?

1) 3)

2) 4)

What are you allergic to? _____

Who is your Primary Care (Family) Doctor?

Name:_____ Clinic:_____

Previous OB/GYN: _____

Clinic:_____ Phone:_____

Pharmacy: _____

Social History: Do you smoke? Yes or No

Use recreational drugs? Yes or No

How much alcohol do you drink a week? _____

Do you have any medical problems?

(circle all that apply)

Diabetes High Blood Pressure

Heart Disease Liver Disease

Kidney Disease Thyroid Disease

Asthma History of TB or +PPD

Depression/Anxiety DVT or PE Cancer

Other: _____

Gynecology History:

1) How old were you when your periods started? _____

2) Do you get a period every month? Yes or No

3) How long are your menstrual cycles? _____ days

(count from first day of one period to first day of next period)

4) Are your periods heavy? Yes or No

5) How long do your periods last? _____ days

6) Do you bleed between periods? Yes or No

7) Do you have menstrual cramps? Yes or No

8) When did your last period start? _____

9) Are you having sex? Yes or No

10) What birth control do you use? _____

11) Have you had: an ABNORMAL pap test? Yes or No

a sexually transmitted infection? Yes or No

12) Did you get the HPV vaccine? Yes or No

What surgeries have you had?

1)

2)

Pregnancy History:

(How many?)

Pregnancies: _____

Deliveries: _____

Miscarriages: _____

Abortions: _____

Date	**Type of Delivery** (Vaginal or Cesarean Section)	**Term** or **Preterm**	**Baby weight**	**Complications?** (preeclampsia, diabetes, shoulder dystocia, hemorrhage)