Please complete this form and:

North Park OB-GYN Associated

- ☐ Bring it to your appointment
- ☐ Mail it in the enclosed envelope
- ☐ Fax it to: (423) 875-8510 at least one day before your appointment.

Today's date: _____ / _____ / _____

Name _____ Preferred Name _____

Address _____

Birth date _____ / _____ / _____ Social Security Number _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Primary Physician _____ Partner's Name _____

Reason for Visit: ☐ Routine Annual Exam ☐ Problem

Describe Problem _____

CHECK IF YOU HAVE HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST AND LIST DATE:

☐ Anemia	_____	☐ Fracture	_____	☐ Mood Disorders	_____
☐ Anxiety	_____	☐ Glaucoma	_____	☐ Pneumonia	_____
☐ Arthritis/Joint Pain	_____	☐ Gonorrhea / GC	_____	☐ Rheumatic Fever	_____
☐ Asthma	_____	☐ Heart Murmur	_____	☐ Sexually Transmitted Diseases	_____
☐ Blood Transfusions	_____	☐ Heart Trouble	_____	☐ Stroke	_____
☐ Bowel Trouble	_____	☐ Hepatitis/Jaundice	_____	☐ Syphilis	_____
☐ Breast Cancer	_____	☐ Herpes/HSV	_____	☐ Tuberculosis - TB	_____
☐ Cancer	_____	☐ High Blood Pressure	_____	☐ Thyroid Disease	_____
☐ Chicken Pox	_____	☐ High Cholesterol	_____	☐ Ulcers	_____
☐ Chlamydia	_____	☐ HIV/AIDS	_____	☐ Other: _____	
☐ Chronic Lung Disease	_____	☐ HPV/Human Papilloma Virus	_____	_____	
☐ Depression	_____	☐ Kidney Infection	_____	_____	
☐ Diabetes	_____	☐ Urinary Tract Infect	_____	_____	
☐ Eating Disorder	_____	☐ Kidney Stones	_____	_____	

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

Surgery / Hospitalization / Reason	Date

WHEN WAS YOUR LAST TEST OR IMMUNIZATION:

- ☐ Bone Density ..... Date _____
- ☐ Colonoscopy I Sigmoidoscopy ..... Date _____
- ☐ Mammogram ..... Date _____
- ☐ Last Normal PAP Smear ..... Date _____
- ☐ Last Abnormal PAP Smear ..... Date _____

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

Drug Name	*Dosage*	*Physician*

List Any Allergies to Medications/Substances (latex gloves, etc): _____

_____

_____

YOUR GYN HISTORY:

Were you using any birth control when you got pregnant? ☐ Yes ☐ No

☐ Condoms
☐ Depa Provera
☐ Diaphragm
☐ IUD: Kind_____
Date Inserted_____
☐ Birth Control Pill
Name of Pill_____
☐ Contraceptive Foam/Jelly
☐ Nuvaring
☐ Birth Control Patch
☐ None
☐ Natural Family Plan/Rhythm
☐ Tubal Ligation
☐ Vasectomy
☐ Withdrawal
☐ Other:_____

What age did you have your first period?_____
How many days are there from the start of your period to the start of your next period? _____ days
How long does your period last? _____ days Flow: ☐ Light ☐ Medium ☐ Heavy
What number of tampons or pads are used in a day? _____
Do you pass clots? ☐ Yes ☐ No
Date of last period:_____ Are you sure of the date? ☐ Yes ☐ No
Was it a normal period? ☐ Yes ☐ No
Have you had a home urine pregnancy test? ☐ Yes ☐ No When: _____
Have you had an office urine pregnancy test? ☐ Yes ☐ No When: _____
Have you had an office blood pregnancy test? ☐ Yes ☐ No When: _____
Have you had recent abnormal bleeding? ☐ Yes ☐ No When: _____

IF YOU HAVE STOPPED HAVING PERIODS, PLEASE ANSWER THE QUESTIONS BELOW:

Age of Menopause _____ Do you take prescription hormones now? ☐ Yes ☐ No
Did you take hormones in the past? ☐ Yes ☐ No Do you take herbal hormones? ☐ Yes ☐ No

YOUR OB HISTORY:

	NUMBER		*NUMBER*
Total Number of Pregnancies	_____	Full Term Births	_____
Premature Delivery (less than 37 weeks)	_____	Abortions/Termination	_____
Miscarriages	_____	Living Children	_____

On the chart below, please fill in answers for each pregnancy including abortions or miscarriages.

No.	Birth Date	Wks. Gest.	Labor (hrs.)	Baby's Weight/Sex	Del. Type Vag/C-Sect.	Epidural Y/N	Preterm Labor?	Wt. Gain	Comments/Complications	Hospital
1				❒M ❒F						
2				❒M ❒F						
3				❒M ❒F						
4				❒M ❒F						

CHECK ANY THAT APPLY AND LIST IF YOUR BLOOD RELATIVES HAVE HAD:

Major Illnesses	*Yes*	*What Blood Relative?* *Mother's* *Father's*
Anemia		
Arthritis / Joint Pain		
Asthma		
Bowel Troubles / Ulcers		
Breast Cancer		
Cancer		
Chronic Lung Disease		
Depression / Anxiety / Mood Disorders		
Diabetes		
Glaucoma		
Heart Trouble / Murmur		
Hepatitis / Jaundice		
High Blood Pressure		
High Cholesterol		
Kidney Infections / Stones		
Stroke		
Thyroid Disease		
Tuberculosis - TB		
Other		

SOCIAL HISTORY

Do you exercise? ☐ None ☐ Less than 3 times per week ☐ More than 3 times per week
Do you have sex with: ☐ Men ☐ Women ☐ Both
First Intercourse at age:_____ New sexual partner? ☐ Yes ☐ No
Lifetime sexual partners: ☐ Less than 5 ☐ More than 5
Do you have any sexual problems you want to discuss today? ☐ Yes ☐ No
Describe: _____
Do you want to be screened for HIV / AIDS? ☐ Yes ☐ No
Do you want to be screened for other STD's? ☐ Yes ☐ No
Have you ever had a blood transfusion? ☐ Yes ☐ No Date:_____
Smoking: ☐ Yes ☐ No ☐ Previously Packs per day_____ # years_____ Stopped ____ years ago
Alcohol: ☐ Yes ☐ No ☐ Previously Drinks per day_____ Drinks per week_____
Caffeine: ☐ Yes ☐ No Drinks per day_____ Drinks per week_____
Drug user: ☐ Y es ☐ No Kind / Type_____ Frequency_____
History of Abuse: ☐ Y es ☐ No ☐ Physical ☐ Emotional ☐ Sexual
Are you in a relationship with someone who physically threatens or hurts you? ☐ Yes ☐ No
List all "Natural" or "Herbal" remedies, over the counter drugs, vitamins, or minerals you are taking:

_____
_____
_____
_____

Highest Grade Completed in School: ☐ GED ☐ High School ☐ Attended Some College
☐ Associate Degree (2 years) ☐ Bachelor's Degree (4 years) ☐ Post-Graduate
☐ Some Graduate Work ☐ Did not attend school ☐ Did not complete high school
Other: _____
Occupation: _____
Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ Other_____
Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed

REVIEW OF SYSTEMS

Please check if any of the following applies to you TODAY:

CONSTITUTIONAL		Notes
Weight Loss	☐	
Weight Gain	☐	
Fever	☐	
Fatigue	☐	
Night Sweats	☐	
Hot Flashes	☐	
EYES		
Double vision	☐	
Vision Changes	☐	
HENT		
Headaches	☐	
Dizziness	☐	
Sore Throat	☐	
Sinus Pain	☐	
Nose Bleeding	☐	
Thyroid Mass	☐	
Neck Pain	☐	
BREASTS		
Lumps	☐	
Tenderness	☐	
Swelling	☐	
Discharge	☐	
Pain in Breast	☐	
Abn. Changes in Breast	☐	
CARDIOVASCULAR		
Chest Pain	☐	
Irregular Heart Beats	☐	
Rapid Heart Rate	☐	
Fainting	☐	
Swelling of Legs	☐	
Varicose Veins	☐	
RESPIRATORY		
Wheezing	☐	
Cough	☐	
Shortness of Breath	☐	
Spitting Up Blood	☐	
GASTROINTESTINAL		
Nausea	☐	
Vomiting	☐	
Diarrhea	☐	
Constipation	☐	
Abdominal Pain	☐	
Bloody /Black Stool	☐	
Hemorrhoids	☐	
Jaundice	☐	
GENITOURINARY		
Urgency of Urination	☐	
Frequency of Urination	☐	
Pain with Urination	☐	
Nighttime Urination	☐	
Losing Urine	☐	

GENITOURINARY, Continued		Notes
Decreased Sex Drive	☐	
Painful Intercourse	☐	
Possible Pregnancy	☐	
Genital Sores	☐	
SKIN		
Rashes	☐	
Itching	☐	
Skin Dryness	☐	
Skin Lesions	☐	
Changes to Lesions or Moles	☐	
Acne	☐	
NEUROLOGICAL		
Muscular Weakness	☐	
Numbness or Tingling	☐	
Difficulty Concentrating	☐	
Memory Difficulties	☐	
Speech Difficulties	☐	
Seizures	☐	
Loss of Balance	☐	
MUSCULOSKELETAL		
Joint Pain or Swelling	☐	
Muscle Pain	☐	
Back Pain	☐	
ENDOCRINE		
Loss of Hair	☐	
Difficulty Tolerating Cold	☐	
Difficulty Tolerating Heat	☐	
PSYCHIATRIC		
Anxiety	☐	
Depression	☐	
Impulsive Behavior	☐	
Suicidal Thoughts	☐	
Excessive Anger	☐	
Mood Swings	☐	
Emotional Abuse	☐	
Physical Abuse	☐	
Sexual Abuse	☐	
HEMATOLOGIC/LYMPHATIC		
Bruises Frequently or Easily	☐	
Cuts do not stop bleeding	☐	
Enlarged Lymph Nodes	☐	
ALLERGIC/IMMUNOLOGIC		
Frequent Illness	☐	
Seasonal Allergies	☐	

OTHER

1. _____

2. _____