WOMEN'S MEDICAL SPECIALTY **INITIAL EXAM**

Patient's Name: _____ Age: _____ Birth Date: ___/___/___ Today's Date : ___/___/___

Primary Care Physician: _____

Reason for appointment: _____

_____

_____

Menstrual History

First day of last menstrual period: ___/___/___ Age at first period: _____ Are your periods regular? ☐ Yes ☐ No

Days between periods (start to start) _____ Days your period last? _____ Are they heavier then past? ☐ Yes ☐ No

Hysterectomy ☐ Yes ☐ No If periods stopped, at what age _____ Are you currently sexually active? ☐ Yes ☐ No

Current birth control ☐ None ☐ Birth Control Pills ☐ Tubal ligation ☐ IUD ☐ Condoms

☐ Depoprovera ☐ Nuvaring ☐ Vasectomy ☐ Patch ☐ Implanon ☐

Are you trying to get pregnant? ☐ Yes ☐ No If yes for how many months_____

Comments: _____

_____

_____

Obstetrical History

Number of Pregnancies ____ Births ____ Miscarriages ____ Abortions ____

Vaginal births _____ Caesarean births _____ Vaginal births after Caesarean births _____

Comments: _____

_____

Past Medical & Family History

	Self	Fam		Self	Fam		Self	Fam
Cancer	☐	☐	High Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Osteoporosis	☐	☐	Heart Disease	☐	☐	Other (please specify) _____		
Diabetes	☐	☐	High Cholesterol	☐	☐	_____		

Do You Presently Have? (Please check all that apply): ☐ **NONE**

- ☐ Abnormal menstrual bleeding
- ☐ Severe pain with your periods
- ☐ Changes in your breasts
- ☐ Abnormal vaginal discharge
- ☐ Vaginal burning or itching
- ☐ Vaginal odor
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Poor appetite
- ☐ Depression
- ☐ Concerns about bowel movements
- ☐ Concerns about urination
- ☐ Urine leakage that concerns you
- ☐ Recent unexplained weight changes
- ☐ STD Exposure
- ☐ History of abnormal Pap smear
- ☐ Abnormality on self breast exams
- ☐ Other (please specify): _____

Comments: _____

_____

_____

Surgeries or Hospitalizations ☐ **NONE**

Type of Surgery or Reason for Hospitalization (Please include dates)

1. _____
2. _____
3. _____

List any drug/food allergies: ☐ **NONE** If yes, please specify _____

Medications-Please list ***all*** current medications (including prescriptions, hormone replacement, vitamins, calcium & over the counter medications)

☐ **NONE**

Medication

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

WOMEN'S MEDICAL SPECIALTY **INITIAL EXAM**

Patient's Name: _____ **Date:** _____

Social History

	Yes	No	
Exercise regularly?	☐	☐	If so, how often _____
Smoke cigarettes?	☐	☐	If so, how many packs per days _____
Drink alcohol regularly?	☐	☐	If so, how many drinks per week _____
Are you under stress that you cannot manage?	☐	☐	
Do you have any questions about domestic/sexual abuse?	☐	☐	

Screening Tests –Have you had (please check all that apply & provide dates, if applicable)

	Date		Date	Comments
☐ Previous Gynecology Exam	__/__/__	☐ Cholesterol Screening	__/__/__	_____
☐ Previous Pap smear	__/__/__	☐ Diabetes Screening	__/__/__	_____
☐ Abnormal Pap smear	__/__/__	☐ Hepatitis B vaccine	__/__/__	_____
☐ Mammography	__/__/__	☐ HPV vaccine	__/__/__	_____
☐ Colonoscopy	__/__/__	☐		_____