Camellia Women's Health

COMPREHENSIVE OB/GYN SERVICES **Date:**

Name:	**Date of Birth:**

MEDICAL HISTORY

❑ **No medical problems**		
❑ Anemia	❑ Chronic Pain	❑ Hypertension
❑ Anxiety	❑ Depression	❑ High Cholesterol
❑ Asthma	❑ Diabetes	❑ Thyroid disease
❑ Blood Transfusion	❑ Emphysema / COPD	❑ Osteoporosis / Thin Bones
❑ Cancer, type:	❑ Heart Disease	❑ Other, please list:

SURGERY HISTORY

❑ **No surgeries**				
❑ Tonsillectomy	❑ Appendectomy	❑ Gallbladder	❑ Gastric Bypass	❑ Mastectomy
❑ Heart surgery	❑ Hysterectomy	❑ Removal of ovary	❑ Other, please list:	

FAMILY HISTORY

❑ **Adopted**	
Mother: ❑ Living ❑ Deceased Age: ____ Medical problems:	**Father:** ❑ Living ❑ Deceased Age: ____ Medical problems:
Siblings: Number living: Medical problems / Age:	
Any family member with Ovarian Cancer? ❑ YES ❑ NO Any family member with Colon Cancer? ❑ YES ❑ NO Any family member with Breast Cancer? ❑ YES ❑ NO Does anyone in your family have the BRCA gene? ❑ YES ❑ NO ❑ Not sure	Any family member with other cancer? ❑ YES ❑ NO If yes, please list:

SOCIAL HISTORY

Occupation:		Highest level of education:
Tobacco use ❑ YES ❑ NO # packs/day ____ # years ____ year quit ____	Second hand smoke ❑ YES ❑ NO Street drug use ❑ YES ❑ NO Type _____ Last used _____	Do you exercise? ❑ YES ❑ NO # days/week ____ type of exercise _____ Have you been abused? ❑ YES ❑ NO
Alcohol use ❑ YES ❑ NO # drinks/day____	Narcotic pain pills ❑ YES ❑ NO Caffeine intake ❑ YES ❑ NO	Are you safe now? ❑ YES ❑ NO Do you wear a seatbelt? ❑ YES ❑ NO

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Name:	**Date of Birth:**

OBSTETRIC HISTORY

❑ **I have never been pregnant**

	Number		***Number***		***Number***
All pregnancies		*Abortions*		*Live Births*	
Premature births (<37 weeks)		*Miscarriages*		*Living Children*	

#	**Birth Date**	**Baby's Weight**	**Baby's Sex**	**Weeks Pregnant**	**Type of Delivery**	**Complications**
1						
2						
3						
4						
5						

Have you ever had any of the following pregnancy complications?

❑ Diabetes ❑ Hypertension / High Blood Pressure ❑ Preeclampsia / Toxemia ❑ Hemorrhage ❑ Preterm birth

*** Please list any additional pregnancies on the back of this page**

GYNECOLOGIC HISTORY

Age of your first period: First day of your last period:

Days between periods: # Days of bleeding: Are your cycles: ❑ regular ❑ irregular

Do you have any of the following?

Pain or cramps with period ❑ YES ❑ NO
Excessively heavy periods ❑ YES ❑ NO
Bleeding between periods ❑ YES ❑ NO
Bleeding after intercourse ❑ YES ❑ NO
Have you had treatment for heavy periods? ❑ YES ❑ NO
Treatments tried:

Sexual Health:

Are you currently sexually active? ❑ YES ❑ NO
Have you been sexually active in the past? ❑ YES ❑ NO
Are your partners: ❑ Male ❑ Female ❑ Both
Do you have pain during sex? ❑ YES ❑ NO
Do you have any concerns about your sexual health you wish to discuss? ❑ YES ❑ NO

Family Planning:

Are you considering a pregnancy? ❑ YES ❑ NO
Are you using birth control? ❑ YES ❑ NO
❑ Natural Family Planning ❑ Condom
❑ Pills ❑ Patch ❑ NuvaRing
❑ Mirena IUD ❑ ParaGard IUD ❑ Implant
❑ Vasectomy ❑ Tubal Ligation
Are you happy with your method? ❑ YES ❑ NO

Sexually Transmitted Infections:

Have you ever had any of the following?
❑ Chlamydia ❑ Gonorrhea ❑ Herpes
❑ Syphilis ❑ Genital Warts ❑ HIV
❑ Other, please list:
Do you use condoms? ❑ YES ❑ NO
Have you had unprotected sex recently? ❑ YES ❑ NO
Would you like to be tested? ❑ YES ❑ NO

Pap Screening:

Date of last pap smear: _____ ❑ Normal ❑ Abnormal
Have you ever had an abnormal Pap? ❑ YES ❑ NO
Have you had a cervical biopsy? ❑ YES ❑ NO
Have you had the HPV vaccine? ❑ YES ❑ NO
Have you had cryotherapy, cone, or LEEP? ❑ YES ❑ NO

Other Gynecologic Problems:

Do you have vaginal discharge today? ❑ YES ❑ NO
Do you have frequent yeast infections? ❑ YES ❑ NO
Do you have ovarian cysts? ❑ YES ❑ NO
Do you have a bulge from the vagina? ❑ YES ❑ NO
Do you have fibroids? ❑ YES ❑ NO

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Name:	**Date of Birth:**

MEDICATIONS

**** Please include any over-the-counter (non-prescription), vitamins, and/or herbal medications you take ****

Name of Medication	Dose	Year Started	Prescribing Doctor

ALLERGIES

Food, Medication, Latex, etc…	Reaction	Year Noticed

IMMUNIZATION RECORD

Please indicate if you have had the following vaccines

Influenza (flu shot)	❑ YES ❑ NO	Date: _____	MMR (measles, mumps, rubella)	❑ YES ❑ NO	Date: _____
Tdap (Whooping Cough)	❑ YES ❑ NO	Date: _____	Pneumococcal (Pneumonia)	❑ YES ❑ NO	Date: _____
Varicella	❑ YES ❑ NO	Date: _____	Meningococcal (Meningitis)	❑ YES ❑ NO	Date: _____
HPV	❑ YES ❑ NO	Date: _____	Hepatitis A	❑ YES ❑ NO	Date: _____
Zoster (Shingles)	❑ YES ❑ NO	Date: _____	Hepatitis B	❑ YES ❑ NO	Date: _____

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Name:	**Date of Birth:**

General Health:		**Eyes & Ears:**	
Any changes in your health since last visit?	❑ YES ❑ NO	Do you wear glasses or contacts?	❑ YES ❑ NO
Have you gained weight since last visit?	❑ YES ❑ NO	Have you had changes in your vision?	❑ YES ❑ NO
Have you lost weight since last visit?	❑ YES ❑ NO	Do you have dry eyes?	❑ YES ❑ NO
Do you have fever or chills?	❑ YES ❑ NO	Do you use a hearing aid?	❑ YES ❑ NO
Do you have trouble sleeping?	❑ YES ❑ NO	Have you had changes in your hearing?	❑ YES ❑ NO
Cardiovascular:		**Mouth & Throat:**	
Do you have chest pain?	❑ YES ❑ NO	Do you see a dentist?	❑ YES ❑ NO
Do you ever have shortness or breath?	❑ YES ❑ NO	Do you wear dentures?	❑ YES ❑ NO
Do you have swelling in your legs?	❑ YES ❑ NO	Do you have dry mouth?	❑ YES ❑ NO
Do you have difficulty breathing at night?	❑ YES ❑ NO	Do you ever have bleeding from the mouth?	❑ YES ❑ NO
Do you have a heart murmur?	❑ YES ❑ NO	Do you have sores in your mouth?	❑ YES ❑ NO
Does your heart ever skip a beat?	❑ YES ❑ NO	Do you have hoarseness?	❑ YES ❑ NO
Respiratory:		**Hematologic:**	
Do you have a chronic cough?	❑ YES ❑ NO	Do you bruise or bleed easily?	❑ YES ❑ NO
Do you cough up blood?	❑ YES ❑ NO	Are you easily fatigued or tired?	❑ YES ❑ NO
Do you have wheezing?	❑ YES ❑ NO	Do you have swollen glands?	❑ YES ❑ NO
Gastrointestinal:		**Skin & Hair:**	
Have you had changes in appetite?	❑ YES ❑ NO	Do you have any rashes?	❑ YES ❑ NO
Do you have trouble swallowing?	❑ YES ❑ NO	Have you noticed changing moles?	❑ YES ❑ NO
Do you have heartburn or reflux?	❑ YES ❑ NO	Have you noticed changed in your nails?	❑ YES ❑ NO
Do you have nausea?	❑ YES ❑ NO	Have you had hair loss or changes in hair?	❑ YES ❑ NO
Do you have diarrhea?	❑ YES ❑ NO	**Musculoskeletal:**	
Do you have constipation?	❑ YES ❑ NO	Do you have muscle pain?	❑ YES ❑ NO
Do you ever have blood in the stool?	❑ YES ❑ NO	Do you have join pain or weakness?	❑ YES ❑ NO
Do you ever have black or tarry stools?	❑ YES ❑ NO	Do you have swelling of the joints?	❑ YES ❑ NO
Have you noticed change in your stools?	❑ YES ❑ NO	Do you have chronic back or neck pain?	❑ YES ❑ NO
Do you have yellowing of the skin or eyes?	❑ YES ❑ NO	Have you had a serious injury or trauma?	❑ YES ❑ NO
Neurologic:		**Psychiatric:**	
Do you get frequent headaches?	❑ YES ❑ NO	Have you had a depressed mood?	❑ YES ❑ NO
Do you experience dizziness or fainting?	❑ YES ❑ NO	Do you feel worried or anxious?	❑ YES ❑ NO
Have you ever had a seizure?	❑ YES ❑ NO	Are you under a lot of stress?	❑ YES ❑ NO
Do you have numbness or tingling?	❑ YES ❑ NO	Have you experienced memory loss?	❑ YES ❑ NO
Do you have weakness?	❑ YES ❑ NO	Do you have trouble concentrating?	❑ YES ❑ NO
Breast health:		**Bladder health:**	
Do you perform a self-breast exam?	❑ YES ❑ NO	Do you have burning with urination?	❑ YES ❑ NO
Have you ever noticed a lump?	❑ YES ❑ NO	Have you had blood in the urine?	❑ YES ❑ NO
Bleeding or discharge from nipple?	❑ YES ❑ NO	Do you have UTIs (bladder infections)?	❑ YES ❑ NO
Family member with breast cancer?	❑ YES ❑ NO	Do you leak with cough or sneeze?	❑ YES ❑ NO
Have you ever had a mammogram?	❑ YES ❑ NO	Do you have sudden urges to urinate?	❑ YES ❑ NO
Last mammogram: _____	❑ Normal ❑ Abnormal	Do you awake frequently at night to urinate?	❑ YES ❑ NO
Have you ever had a breast biopsy?	❑ YES ❑ NO	Do you ever have leaking accidents?	❑ YES ❑ NO