



Camellia Women's Health

COMPREHENSIVE OB/GYN SERVICES

Date:

Name:	Date of Birth:
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MEDICAL HISTORY

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

SURGERY HISTORY

<input type="checkbox"/> No surgeries				
<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Gastric Bypass	<input type="checkbox"/> Mastectomy
<input type="checkbox"/> Heart surgery	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Removal of ovary	<input type="checkbox"/> Other, please list:	

FAMILY HISTORY

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

SOCIAL HISTORY

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



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OBSTETRIC HISTORY

<input type="checkbox"/> I have never been pregnant						
	<i>Number</i>			<i>Number</i>		
<i>All pregnancies</i>		<i>Abortions</i>		<i>Live Births</i>		
<i>Premature births (<37 weeks)</i>		<i>Miscarriages</i>		<i>Living Children</i>		
#	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?						
<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension / High Blood Pressure <input type="checkbox"/> Preeclampsia / Toxemia <input type="checkbox"/> Hemorrhage <input type="checkbox"/> 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: <input type="checkbox"/> regular <input type="checkbox"/> irregular	
Do you have any of the following?		Sexual Health:	
Pain or cramps with period	<input type="checkbox"/> YES <input type="checkbox"/> NO	Are you currently sexually active?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Excessively heavy periods	<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you been sexually active in the past?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bleeding between periods	<input type="checkbox"/> YES <input type="checkbox"/> NO	Are your partners:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both
Bleeding after intercourse	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have pain during sex?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you had treatment for heavy periods?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have any concerns about your sexual health you wish to discuss?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Treatments tried:			
Family Planning:		Sexually Transmitted Infections:	
Are you considering a pregnancy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you ever had any of the following?	
Are you using birth control?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Gonorrhea
<input type="checkbox"/> Natural Family Planning	<input type="checkbox"/> Condom	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Genital Warts
<input type="checkbox"/> Pills	<input type="checkbox"/> NuvaRing	<input type="checkbox"/> Other, please list:	<input type="checkbox"/> HIV
<input type="checkbox"/> Mirena IUD	<input type="checkbox"/> ParaGard IUD	Do you use condoms?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Vasectomy	<input type="checkbox"/> Tubal Ligation	Have you had unprotected sex recently?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you happy with your method?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Would you like to be tested?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pap Screening:		Other Gynecologic Problems:	
Date of last pap smear: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Do you have vaginal discharge today?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever had an abnormal Pap?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have frequent yeast infections?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you had a cervical biopsy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have ovarian cysts?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you had the HPV vaccine?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have a bulge from the vagina?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you had cryotherapy, cone, or LEEP?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have fibroids?	<input type="checkbox"/> YES <input type="checkbox"/> NO



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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)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date: _____	MMR (measles, mumps, rubella)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date: _____
Tdap (Whooping Cough)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date: _____	Pneumococcal (Pneumonia)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date: _____
Varicella	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date: _____	Meningococcal (Meningitis)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date: _____
HPV	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date: _____	Hepatitis A	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date: _____
Zoster (Shingles)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date: _____	Hepatitis B	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date: _____



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<p>General Health:</p> <p>Any changes in your health since last visit? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you gained weight since last visit? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you lost weight since last visit? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have fever or chills? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have trouble sleeping? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Eyes & Ears:</p> <p>Do you wear glasses or contacts? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you had changes in your vision? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have dry eyes? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you use a hearing aid? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you had changes in your hearing? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>Cardiovascular:</p> <p>Do you have chest pain? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you ever have shortness or breath? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have swelling in your legs? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have difficulty breathing at night? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have a heart murmur? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Does your heart ever skip a beat? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Mouth & Throat:</p> <p>Do you see a dentist? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you wear dentures? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have dry mouth? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you ever have bleeding from the mouth? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have sores in your mouth? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have hoarseness? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>Respiratory:</p> <p>Do you have a chronic cough? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you cough up blood? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have wheezing? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Hematologic:</p> <p>Do you bruise or bleed easily? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Are you easily fatigued or tired? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have swollen glands? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>Gastrointestinal:</p> <p>Have you had changes in appetite? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have trouble swallowing? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have heartburn or reflux? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have nausea? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have diarrhea? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have constipation? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you ever have blood in the stool? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you ever have black or tarry stools? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you noticed change in your stools? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have yellowing of the skin or eyes? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Skin & Hair:</p> <p>Do you have any rashes? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you noticed changing moles? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you noticed changed in your nails? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you had hair loss or changes in hair? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>Neurologic:</p> <p>Do you get frequent headaches? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you experience dizziness or fainting? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you ever had a seizure? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have numbness or tingling? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have weakness? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Musculoskeletal:</p> <p>Do you have muscle pain? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have joint pain or weakness? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have swelling of the joints? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have chronic back or neck pain? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you had a serious injury or trauma? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>Psychiatric:</p> <p>Have you had a depressed mood? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you feel worried or anxious? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Are you under a lot of stress? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you experienced memory loss? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have trouble concentrating? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Bladder health:</p> <p>Do you have burning with urination? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you had blood in the urine? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have UTIs (bladder infections)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you leak with cough or sneeze? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have sudden urges to urinate? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you awake frequently at night to urinate? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you ever have leaking accidents? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>Breast health:</p> <p>Do you perform a self-breast exam? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you ever noticed a lump? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Bleeding or discharge from nipple? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Family member with breast cancer? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you ever had a mammogram? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">Last mammogram: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p>Have you ever had a breast biopsy? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Bladder health:</p> <p>Do you have burning with urination? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you had blood in the urine? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have UTIs (bladder infections)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you leak with cough or sneeze? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have sudden urges to urinate? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you awake frequently at night to urinate? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you ever have leaking accidents? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>