WEST END OB/GYN, PC

PATIENT ENCOUNTER **TODAYS DATE:_____**

Welcome to our office. Please take a few minutes to provide us with information to better serve you.

Name _____ Email _____

DOB:_____ Sex:_____ Race:_____ Hispanic___ Non-Hispanic___

Pharmacy Name:_____Pharmacy#:_____

Primary Care Physician (PCP)_____Office#_____

What is the nature of your visit? ☐ Annual exam ☐ Consultation ☐ Pregnancy: Last Period:_____

☐ Problem Visit (please explain) _____

How did you learn about this office? _____

Please check any medical problems that a doctor is treating.

	Condition	Year Diagnosed	Doctor Treating		Condition	Year Diagnosed	Doctor Treating
	Hypertension				Asthma		
	High Cholesterol				C-section		
	Diabetes				Seasonal Allergies		
	Thyroid				Other:		
	Depression						
	Anxiety						
	Osteoporosis						
	Osteopenia						

Please list any previous surgery(ies). (Example: tubal ligation, appendectomy, hysterectomy, colposcopy)

Surgery	Year	Doctor	Surgery	Year	Doctor

Please list current medications including dosing.

Medication	Dosage	Medication	Dosage

Have you had the flu vaccine this year? ☐ Yes ☐ **No If so, When?_____Where?_____**

Please list any allergies to medications. **Please list all other allergies. (Example: latex, food)**

MEDICATION	REACTION		ALLERGY	REACTION

Please tell us about any previous pregnancies. ☐ **Does not apply, I have never been pregnant before.**

	Total # of times pregnant		# of Vaginal Deliveries
	# of Miscarriages		# of C-Sections
	# of Abortions		# of Living Children

Have you ever had any **previous GYN problems?** (Please check box for those that apply)

	Abnormal Pap? Date_____		STD: Date_____
	Abnormal Mammogram? Date:_____		Problems with Menstrual Cycle Date this Began_____:
	History of Cold Sores/Fever Blisters: Date_____		Do you use Birth Control ☐ Yes ☐ **No** If yes, what form: _____

Please check the box below if you have **previously received the Human Papilloma Virus (HPV) injection, also called Gardasil, at another medical facility.**

☐ I have received the HPV vaccination. It was given to me at _____.
(name of facility)

I received a total of (please check box) ☐ 1, ☐ 2, ☐ 3 HPV injections

Family History: (check all that applies) **Family History Unknown** ☐ (check if this applies to you)

	Hyper-tension	Diabetes	High Cholesteol	Thyroid	Heart Disease	Breast Cancer	Colon Cancer	Uterine Cancer	Ovarian Cance	Other:__
Mother										
Father										
Sibling										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										
Aunt										
Uncle										

Social History: (check history that applies)

Marital Status: ☐Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Domestic Partner ☐ Other_____

Are you employed? ☐ Yes ☐ No What occupation? _____

Do you use alcohol? ☐Yes ☐ No If so, how often? _____

Illegal drug use, past or present? ☐Yes ☐ No

Do you wear a seat belt? ☐Yes ☐ No Do you exercise regularly? ☐Yes ☐ No How Often: _____

Have you ever experienced domestic abuse (Physical)? ☐Yes ☐ No (Emotional) ☐Yes ☐ No

Tobacco Use: ☐Former User ☐ Current User Form of Tobacco: _____

If so, Age Started _____How Much Daily?_____Date of Last Use of Tobacco:_____

If you do use Tobacco would you like information on how to quit? ☐Yes ☐ No