# PINEVIEW GYNECOLOGY

**Name:** _____ **Nickname:** _____ **DOB:** _____

**Reason for your visit today:** ☐ Annual Well-Woman Exam ☐ Other: _____

**Referred by:** _____ **City/State:** _____ **Phone #** _____
**Primary Care Physician:** _____ **City/State:** _____ **Phone #** _____

**Gynecologic History:**
Last Menstrual Period: _____
Age of First Period: _____
Period every _____ days. Lasts _____ days.
☐ Heavy periods ☐ Cramps
Last Pap Smear _____
History of Abnormal Pap: ☐ Yes ☐ No
Gardasil/HPV Vaccine _____ Date: _____
Treatment for Abnormal Pap: ☐ Yes ☐ No
Sexually Active: ☐ Yes ☐ Not Currently ☐ Never
☐ Male Partner ☐ Female Partner
Contraception Method: _____
History of STDs: ☐ Yes ☐ No
Would you like to be tested for STDs? ☐Yes ☐ No
Do you do regular Breast Self-Exams: ☐ Yes ☐ No
Last Mammogram and Location: _____
Hysterectomy: Year _____ Age _____
Age of Menopause: _____
Colonoscopy: ☐ No ☐ Yes-Year/Location/Provider/Results _____
Previous DEXA Bone Density Scan: ☐ No ☐ Yes - Year _____

**Obstetrical History:**
Number of Pregnancies: _____
Number of Full-Term Births: _____
Number of Pre-term Births: ___Weeks___
Miscarriages: ____ Abortions: ____
Ectopic/Tubal Pregnancies: _____
Multiple Births: _____
Living Children: _____
C-Section: _____
Vaginal Delivery _____
Complications: _____ None

Vaccines:
Flu _____ Date: _____
Shingles _____ Date: _____
Pneumovax _____ Date: _____

**Social History**
Do you drink Alcohol? ☐ Never ☐ Rare ☐ Occasional _____ drinks/week
Do you smoke cigarettes? ☐ No ☐ Yes _____ packs/day ☐ Quit smoking _____ (year)
What is your diet like? _____
Are you: ☐ Single ☐ Married ☐ Engaged ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with Partner
Do you exercise regularly? ☐Yes ☐ No
What is your occupation? _____
Use any illicit drugs? ☐ Yes ☐ No
Do you wear your seatbelt? ☐ Yes ☐ No
Have you ever been abused? ☐ No ☐ Physically ☐ Sexually ☐ Emotionally
Are you safe now? ☐ Yes ☐ No
Advance Directive/Living Will? ☐Yes ☐No
Have you been tested for ☐ HIV ☐ Hep C
In the past 3 weeks, have you traveled outside the country? ☐Yes ☐No Where? _____

**Pharmacy Name/Location:** _____ **City/State:** _____

**Reviewed By:**
**Date:** _____

***Complete Reverse Side***

**Name:** _____ **DOB:** _____

**Medications/Dose/Frequency:** Include vitamins, herbal, and over the counter medicines

| | |
|---|---|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

**Allergies/Reaction**

| | |
|---|---|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |
| ☐ **No Known Drug Allergies** | |

**Past Medical History:**

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Stroke
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ GERD/Reflux
- ☐ Thyroid Disease
- ☐ Diverticulosis/Diverticulitis
- ☐ Asthma
- ☐ COPD
- ☐ Kidney Stones
- ☐ Migraines/Headaches
- ☐ Depression
- ☐ Anxiety/Panic Attacks
- ☐ Cataracts/Macular Degeneration
- ☐ Glaucoma
- ☐ Blood Clots
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Cancer, Type _____
- ☐ Other _____
- ☐ Ashkenazi Jewish Descent

**Surgical History: Please list all surgeries and biopsies:**

| Date (Year) | Procedure | Date (Year) | Procedure |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have you ever had any problems with Anesthesia? ☐ Yes ☐ No Blood Transfusion? ☐ Yes ☐ No

**Family History:**

| Disease | Family Relation | Maternal or Paternal Side | Age Diagnosed | Age of Death |
|---|---|---|---|---|
| ☐ High Blood Pressure | | | | |
| ☐ Diabetes | | | | |
| ☐ Heart Attack | | | | |
| ☐ Heart Disease | | | | |
| ☐ Stroke | | | | |
| ☐ Depression | | | | |
| ☐ Anxiety | | | | |
| ☐ Thyroid Disease | | | | |
| ☐ Elevated Cholesterol | | | | |
| ☐ Osteoporosis | | | | |
| ☐ Breast Cancer | | | | |
| ☐ Ovarian Cancer | | | | |
| ☐ Uterine Cancer | | | | |
| ☐ Colon Cancer | | | | |
| ☐ Other Cancer, Type | | | | |
| ☐ OTHER: | | | | |

**Reviewed By:**
**Date:**