

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: _____

Complete Reverse Side

Reviewed By: _____
Date: _____

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.
<input type="checkbox"/> No Known Drug Allergies	

Past Medical History:

- | | | |
|---|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> Anxiety/Panic Attacks |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cataracts/Macular Degeneration |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diverticulosis/Diverticulitis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> COPD | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> Cancer, Type _____ |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Depression | <input type="checkbox"/> Other _____ |
| | | <input type="checkbox"/> 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
<input type="checkbox"/> High Blood Pressure				
<input type="checkbox"/> Diabetes				
<input type="checkbox"/> Heart Attack				
<input type="checkbox"/> Heart Disease				
<input type="checkbox"/> Stroke				
<input type="checkbox"/> Depression				
<input type="checkbox"/> Anxiety				
<input type="checkbox"/> Thyroid Disease				
<input type="checkbox"/> Elevated Cholesterol				
<input type="checkbox"/> Osteoporosis				
<input type="checkbox"/> Breast Cancer				
<input type="checkbox"/> Ovarian Cancer				
<input type="checkbox"/> Uterine Cancer				
<input type="checkbox"/> Colon Cancer				
<input type="checkbox"/> Other Cancer, Type				
<input type="checkbox"/> OTHER:				

<p>Reviewed By: Date:</p>
