PINEVIEW GYNECOLOGY

Name: ______________________________________**Nickname**:___________________**DOB**:________________

Preferred Contact Phone #: _____________ **Ethnic Group:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐American Indian ☐Asian ☐African American ☐Caucasian ☐ Pacific Islander ☐ Other _________

Language: ☐ English ☐ Spanish ☐Arabic ☐ Hebrew ☐ Cantonese ☐ Japanese ☐ Korean
☐ Mandarin ☐ Russian ☐ Other ______________

Referred by:___________________________ **Physician Phone #:** __________ **City/State:** _______________
Primary Care Physician:_________________ **Physician Phone #:** ___________ **City/State:** _______________

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

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

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
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:
Gardasil _________ Date: __________
Flu _______ Date: _________
Shingles ________ Date: __________
Pneumovax ________ Date: __________

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.
☐ **No Known Drug Allergies**	

Pharmacy Name/Location: ______________________ **City:** ______________**Phone Number:**__________

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 being hit, hurt, or frightened by anyone in your life? ☐ Yes ☐ No
Advance Directive/Living Will? ☐Yes ☐No
Have you been tested for ❑ HIV ❑ Hep C
In the past 3 weeks, have you traveled to Liberia, Sierra Leone, or Guinea or have a history of exposure to a person with known Ebola virus? ❑Yes ❑No If yes, please inform a staff person immediately.

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: