OBSTETRICS AND GYNECOLOGY
FOLLOW UP PATIENT HISTORY

Name ______________________ Date of Birth ____________ Today's date ____________

Primary Care Physician ____

Preferred Pharmacy ____________ Address ______________________ Phone ____________

Reason for today's visit ____

Date of last menstrual period ______________

Do you ever have problems with urinating such as infections, frequency, loss of urine, blood in your urine?

____

Have you had frequent vaginal infections? YES ☐ NO ☐ ______________________________

Are your periods regular? YES ☐ NO ☐ Heavy? YES ☐ NO ☐ Painful? YES ☐ NO ☐

Do you do breast self exams? YES ☐ NO ☐

HEALTH MAINTENANCE

PROCEDURE	DATE	RESULTS
LAST PAP SMEAR		
LAST MAMMOGRAM		
LAST BONE DENSITY		
LAST COLONOSCOPY		
LAST CHOLESTEROL		

Since your last visit have you been diagnosed with a new medical condition? YES ☐ NO ☐ ____________

Since your last visit have you had any surgery? YES ☐ NO ☐ ____________

Since your last visit have there been any changes in your family's medical history? YES ☐ NO ☐ ____________

Do you currently have a partner? YES ☐ NO ☐ Partner's gender ____________

How long have you been in this relationship? ____________

Are you currently sexually active? YES ☐ NO ☐

Are you experiencing any sexual problems? YES ☐ NO ☐ ____________________

Marital status single ☐ married ☐ separated ☐ divorced ☐ widowed ☐

Current birth control:

☐ None ☐ timing ☐ condoms ☐ diaphragm ☐ birth control pills/patch/ring

☐ Implants ☐ DepoProvera ☐ IUD ☐ tubal ligation ☐ vasectomy

Occupation ____

Tobacco ☐ YES ☐ NO ☐ QUIT #cigarettes/day __________ # years ____________

Alcohol ☐ YES ☐ NO ☐ QUIT #drinks per day/week ______ type ____________

Drugs ☐ YES ☐ NO ☐ QUIT ______________________________

Exercise ☐ YES ☐ NO #times/week __________ type ____________

Have you been sexually abused, threatened or hurt by anyone? ______________________

Health care proxy YES ☐ NO ☐

Seat belt use YES ☐ NO ☐

MEDICATIONS (including over the counter medications and supplements)

______________________________ ______________________________

______________________________ ______________________________

List any medications or foods that you are **ALLERGIC** to (and the reaction):

____

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

REVIEW OF SYSTEMS

Please circle all that are applicable (within the last 6-12 months)

CONSTITUTIONAL ☐ Negative
- ☐ Fever
- ☐ Chills
- ☐ feeling poorly
- ☐ feeling tired
- ☐ recent weight gain
- ☐ recent weight loss

EYES ☐ Negative
- ☐ Eye Pain
- ☐ Wearing glasses
- ☐ spots before eyes
- ☐ vision changes
- ☐ dry eyes
- ☐ itchy eyes

EAR/NOSE/THROAT ☐ Negative
- ☐ Earaches
- ☐ Loss of hearing
- ☐ nose bleeds
- sinus problems
- ☐ sore throat
- ☐ dental problems

CARDIOVASCULAR ☐ Negative
- ☐ Chest pain
- ☐ Palpitations
- ☐ heart rate is fast
- ☐ heart rate is slow
- ☐ leg swelling (edema)

RESPIRATORY ☐ Negative
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ cough
- ☐ dyspnea (shortness of breath) on exertion
- ☐ shortness of breath with lying flat (orthopnea)
- ☐ respiratory distress in sleep (PND)

GASTROINTESTINAL ☐ Negative
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Nausea
- ☐ constipation
- ☐ diarrhea
- ☐ early satiety
- ☐ heartburn
- ☐ black stool (melena)
- ☐ maroon colored stool (hematochezia)

OB/GYN GU ☐ Negative
- ☐ Frequency
- ☐ Nocturia
- ☐ Dysuria
- ☐ blood in urine
- ☐ cloudy urine
- ☐ odor in urine
- ☐ incomplete emptying of bladder
- ☐ stress incontinence
- ☐ urge incontinence

OB/GYN ☐ Negative
- ☐ Abnormal bleeding
- ☐ Irregular menses
- ☐ Pain with menses
- ☐ Pain with intercourse
- ☐ Anorgasmia
- ☐ vulvar itching
- ☐ midcycle bleeding
- ☐ post coital bleeding
- ☐ vulvar pain
- ☐ decreased libido
- ☐ vaginal itching
- ☐ pelvic pain
- ☐ vaginal dryness
- ☐ vaginal discharge
- ☐ vaginal odor

MUSCULOSKELETAL ☐ Negative
- ☐ Arthralgia (joint pain)
- ☐ joint stiffness
- ☐ joint swelling
- ☐ limb swelling
- ☐ limb pain

INTEGUMENTARY (SKIN) ☐ Negative
- ☐ Acne
- ☐ Breast discharge
- ☐ itching
- ☐ change in a mole
- ☐ breast pain
- ☐ breast lump

NEUROLOGICAL ☐ Negative
- ☐ Confused
- ☐ Memory problems
- ☐ dizziness
- ☐ headaches/migraines
- ☐ limb weakness
- ☐ difficulty walking

PSYCHIATRIC ☐ Negative
- ☐ Suicidal
- ☐ Sleep disturbances
- ☐ anxiety
- ☐ depression
- ☐ change in personality
- ☐ emotional problems

ENDOCRINE ☐ Negative
- ☐ Hair loss
- ☐ Hot flashes
- ☐ Heat/cold intolerance
- ☐ muscle weakness
- ☐ deepening of the voice
- ☐ feeling weak
- ☐ dry skin

HEMATOLOGY/IMMUNOLOGY ☐ Negative
- ☐ Easy bleeding
- ☐ seasonal allergies
- ☐ swollen glands
- ☐ easy bruising