



WOMEN'S  
OB-GYN<sup>PC</sup>

NAME: \_\_\_\_\_

CHT#: \_\_\_\_\_

APPOINTMENT DATE: \_\_\_\_\_

AGE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_

PRIMARY CARE DOCTOR: \_\_\_\_\_

WHY ARE YOU HERE TODAY (CC): \_\_\_\_\_

**DR / PROVIDER  
COMMENTS:**

LOCATION-QUALITY-SEVERITY-DURATION-TIMING-CONTEXT-  
MODIFYING FACTORS-ASSOCIATED SIGNS AND SYMPTOMS

**PATIENT TO COMPLETE BELOW**

Number of pregnancies: \_\_\_\_\_ Number of children: \_\_\_\_\_ # of miscarriages/losses: \_\_\_\_\_  
 Last period: \_\_\_\_\_ Cycle length: \_\_\_\_\_ days  
 Menstrual Flow F Regular Y  N   
 Menstrual Flow Normal Y  N  Medium  Heavy  Clots   
 Normal bleeding: Y  N   
 Painful periods: Y  N   
 Any Meds used: \_\_\_\_\_ Y  N   
 Birth Control Method: \_\_\_\_\_  
 Last Pap smear: \_\_\_\_\_ Y  N   
 Age at First Period: \_\_\_\_\_ Menopause Age : \_\_\_\_\_  
 Painful lovemaking: N  Y   
 Self Breast Exam: N  Y   
 Last Mammogram Normal: N  Y

**PAST MEDICAL HISTORY:** Illnesses: (Diabetes, Hypertension, Heart, Thyroid, Asthma, etc.)

Medications/Supplements/Herbal	Dose/Frequency	Reason

Allergies to Medications or LATEX	Type of reactions (rash, hives, etc.)

Surgeries:(T&A, D&C, C/Section,etc.)	Reason	Who/Where/When	Year

When were your last immunizations: \_\_\_\_\_ Tetanus: \_\_\_\_\_ Pneumococcal: \_\_\_\_\_  
 Hepatitis B: \_\_\_\_\_ Influenza: \_\_\_\_\_ Mumps/Measles/Rubella: \_\_\_\_\_

Bleeding tendency: N  Y  Rheumatic Fever: N  Y   
 Blood transfusions: N  Y  Scarlet Fever: N  Y