South Shore
OBSTETRICS & GYNECOLOGY
Women's Health Care

ID# _____

Name	Date of Birth	Preferred Pharmacy

Constitutional		
Seat belt use	No	Yes
Regular exercise	No	Yes
Recent: □ weight gain □ weight loss	No	Yes
Chronic fatigue	No	Yes
Eyes		
Eye injury	No	Yes
Glaucoma	No	Yes
Blurred vision	No	Yes
Double vision	No	Yes
Do you wear glasses/contacts	No	Yes
Head, Ears, Nose, Mouth, Throat		
Dizziness	No	Yes
Frequent sinus infections	No	Yes
Ear problems	No	Yes
Impaired hearing	No	Yes
Frequent itchy/running nose	No	Yes
Frequent nose bleeds	No	Yes
Frequent mouth sores	No	Yes
Frequent sore throats	No	Yes
Hoarseness	No	Yes
Breasts		
Monthly self exams	No	Yes
Breast tenderness	No	Yes
Breast swelling	No	Yes
Breast lumps	No	Yes
Nipple discharge	No	Yes
Currently breast feeding	No	Yes
Mammogram	No	Yes
Last date:		
Was it normal	No	Yes
Have you had breast cancer	No	Yes
Cardiovascular		
Chest pain or angina	No	Yes
Heart attack	No	Yes
Heart murmur	No	Yes
Shortness of breath with movement	No	Yes
Shortness of breath all the time	No	Yes
Swelling of hands, feet, or ankles	No	Yes
Varicose veins	No	Yes
Inflammation of veins or clots in legs	No	Yes
Recent cholesterol/lipid testing	No	Yes
Testing done by your family doctor	No	Yes
Respiratory		
Difficulty breathing	No	Yes
Wheezing	No	Yes
Coughing up blood	No	Yes

Respiratory continued		
Current common "cold symptoms"	No	Yes
Chronic cough	No	Yes
Frequent bronchitis	No	Yes
Gastrointestinal		
Loss of appetite	No	Yes
Heartburn or indigestion	No	Yes
Vomiting blood	No	Yes
Cramping or pain in the abdomen	No	Yes
Gallbladder disease □ removed (/ /)	No	Yes
Hemorrhoids	No	Yes
Constipation	No	Yes
Frequent diarrhea	No	Yes
Change in bowel habits	No	Yes
Painful bowel movements	No	Yes
Bleeding with bowel movements	No	Yes
Black/tarry stools	No	Yes
Incontinence of stool	No	Yes
Colonoscopy	No	Yes
Last date: Was it normal	No	Yes
Skin		
New lesions	No	Yes
Change in moles:	No	Yes
□ color □ shape □ itching □ irritation		
Rashes	No	Yes
Eczema	No	Yes
Psoriasis	No	Yes
Frequent infections or boils	No	Yes
Jaundice (yellow skin and eyes)	No	Yes
Tanning bed use	No	Yes
Neurological		
Frequent headaches	No	Yes
Current or past fainting spells	No	Yes
Memory difficulties	No	Yes
Balance difficulties	No	Yes
Seizures	No	Yes
Tremors	No	Yes
Lack of Coordination	No	Yes
Numbness or tingling	No	Yes
Musculoskeletal		
Any physical disabilities	No	Yes
Frequent back pain	No	Yes
Joint pain	No	Yes
Joint stiffness	No	Yes
Bone Density Testing	No	Yes
Last date:	No	Yes
Was it normal	No	Yes

Endocrine		
Hormone therapy	No	Yes
If yes, what type:		
Hair loss	No	Yes
Facial hair growth	No	Yes
Intolerant to heat and cold		
Skin is overly dry	No	Yes
Excessive thirst	No	Yes
Excessive urination	No	Yes
Hot flashes	No	Yes
Night sweats	No	Yes
Thyroid Testing & Last date:	No	Yes
Mental Health		
Psychiatric diagnosis	No	Yes
Hospitalized for psychiatric reasons	No	Yes
Attempt(s) to hurt yourself or others	No	Yes
Depression	No	Yes
□ Panic attacks □ Anxiety	No	Yes
Difficulty sleeping	No	Yes
Eating disorders	No	Yes
Other:	No	Yes
Hematological/Lymphatic		
Anemia	No	Yes
Experience excessive bleeding	No	Yes
Do you bruise easily	No	Yes
History of blood transfusion	No	Yes
Unusual swelling or lumps	No	Yes
Allergic/Immunologic		
Seasonal allergic symptoms	No	Yes
History of Chickenpox or immunity	No	Yes
Are you sick a lot	No	Yes
Tetanus immunization in last 10 years	No	Yes
Social/Substance use		
Tobacco: □ never □ quit □ ½ ppd □ 1ppd □ 1ppd +		
Alcohol: □ never □ current # /week, # /month		
Street Drugs: □ never □ minimal □ moderate □ heavy		
Caffeine: □ never □ current # /week, # /month		
Other		
Did your mom take DES while pregnant with you?	No	Yes
Occupation:		
Highest level of education:		
Any other problems/questions?		
Medication Allergies: □ No allergies to medications		
Current Medications: □ No changes from last visit		

Genitourinary		
Any abnormal pap smears, in past 3 years	No	Yes
Pelvic pain	No	Yes
Vaginal □ dryness □ itching	No	Yes
Vaginal odor	No	Yes
Burning/painful urination	No	Yes
Involuntary loss of urine	No	Yes
Frequent urination	No	Yes
Nighttime urination	No	Yes
Foul smelling urine	No	Yes
Blood in urine	No	Yes
Change in urine color	No	Yes
Menstruation □ NA, no periods/reason:		
First day of your last period:		
Age at first menstrual period:		
Irregular periods	No	Yes
How often do you have periods: every days,		
lasting days. ***Is your flow***: □ light □ moderate □ heavy		
Bleeding/spotting between periods	No	Yes
Pass clots with periods: □ small □ large		
Sexual history		
Are you sexually active	No	Yes
History of sexual abuse	No	Yes
History of sexually transmitted infection	No	Yes
History multiple sexual partners (5 or more)	No	Yes
Recent new sexual partner		
Began sexual intercourse before the age 16		
Pain during sex		
Chance you might be pregnant today		
Current method of preventing pregnancies		
□ None (unprotected intercourse)		
□ Natural family planning □ Withdrawal		
□ IUD □ Foam/gel/suppository □ Diaphragm		
□ Depo Provera □ Oral contraceptives □ Condoms		
□ Hysterectomy □ Partner vasectomy □ Tubal		

Surgical history & dates □ No changes from last visit

List all previous hospitalizations, surgeries, and Procedures:

Pregnancy History □ No changes since last visit
of pregnancies:
of deliveries:
Type of deliveries: # Vaginal # C-section
of miscarriages:
abortions:
of living children:
Any pregnancy complications including preterm deliveries: