Put a ✓ if it applies to you

South Shore Obstetrics & Gynecology Women's Health Care

ID# _____

Review of Systems

Name:_____ **DOB: (_____/_____/_____)**

GENITOURINARY

- ☐ Any abnormal pap smears, in past 3 years
- ☐ Pelvic pain
- ☐ Vaginal ☐ dryness ☐ itching
- ☐ Frequent urination
- ☐ Nighttime urination
- ☐ Blood in urine
- ☐ Vaginal odor
- ☐ Burning/painful urination
- ☐ Involuntary loss of urine
- ☐ Bleeding w/ bowel movements
- ☐ Black Tarry Stools

SEXUAL HISTORY

- ☐ Are you sexually active
- ☐ History of sexual abuse
- ☐ History of sexually transmitted infection
- ☐ History of multiple sexual partners (5 or more)
- ☐ Recent new sexual partner
- ☐ Began sexual intercourse before the age of 16
- ☐ Pain during sex
- ☐ Chance you might be pregnant today

MENSTRATION ☐ N/A, no periods/reason:

First day of your last period: _____ **How often do you have periods:** Every _____ days

Age at first menstrual period: _____ Lasting _____ days.

Irregular periods No Yes **Is your flow**: ☐light ☐moderate ☐heavy

Bleeding/spotting between periods No Yes **Pass clots with periods:** ☐ small ☐ large

CURRENT METHOD OF PREVENTING PREGNANCIES

☐ None (unprotected intercourse) ☐ Depo Provera ☐ Oral contraceptives ☐ Condoms

☐ Natural family planning ☐ Withdrawal ☐ Hysterectomy ☐ Tubal

☐ IUD / Nexplanon ☐ Partner Vasectomy ☐ Foam/gel/suppository ☐ Diaphragm

PREGNANCY HISTORY ☐No changes since last visit

of pregnancies _____ # of miscarriages:_____ # of deliveries: _____ # of abortions: _____

# of living children: _____ Type of deliveries: # _____ Vaginal #_____ C-section

Any pregnancy complications including preterm deliveries:_____

Surgical History & dates ☐No changes from last visit

List all previous hospitalizations, surgeries, and procedures:

_____

_____

Have you had Ovarian, or Uterine Cancer? No Yes If yes, when were you diagnosed: _____

Current Medications: ☐No changes from last visit

_____

_____

_____

PHARMACY

Please let us know your preferred pharmacy and location:

_____

_____

Please complete the following side →

Family Medical History

Are you adopted? No Yes **If yes, do you know your family history?** No Yes

Has any blood relative ever had:	No	Maternal Relative (specify)	Paternal Relative (specify)	Has any blood relative ever had:	No	Maternal Relative (specify)	Paternal Relative (Specify)
Blood Disorder				**Cancer (*specify*)**			
Deep Vein Thrombosis				Breast cancer			
Stroke				Colon cancer			
				Ovarian cancer			

Medication Allergies: ☐No allergies to medications

☐ LATEX ALLERGY

SOCIAL / SUBSTANCE USE

Tobacco: ☐never ☐quit ☐1/2ppd ☐1ppd ☐ 1ppd+

Alcohol: ☐never ☐current #_____/week, #_____/month

Caffeine: ☐never ☐current #_____/week, #_____/month

Street Drugs: ☐never ☐Current ☐ Past

Marijuana: ☐never ☐Current ☐ Past

In the last year, have you had any...

☐ Recent weight ☐ gain ☐ loss

☐ Breast tenderness

☐ Breast lumps

☐ Nipple discharge

☐ Currently breast feeding

☐ **Mammogram**

Last date: _____

☐ Was it normal?

☐ Have you had breast cancer?

☐ Chest pain or angina

☐ Difficulty breathing

☐ New lesions

☐ Change in moles: ☐Color ☐Shape ☐Itching ☐Irritation

☐ Hormone therapy

If yes, what type: _____

☐ Hair loss

☐ Facial hair growth

☐ Intolerant to heat and cold

☐ Dry Skin

☐ Bleeding with bowel movements

☐ Incontinence of stool

☐ Frequent headaches/Migraine

☐ ***Bone Density Testing***

Last Date: _____

☐ Was it normal

☐ Hot flashes

☐ Night sweats

☐ Attempt(s) to hurt yourself/others

☐ Depression

☐ Panic attacks

☐ Anemia

☐ Frequent nosebleeds

☐ History of blood transfusion

OTHER Any other problems/questions?