WELCOME TO OUR OFFICE

SW FLORIDA OBGYN, LLC
15641 NEW HAMPSHIRE COURT
FORT MYERS, FL 33908

DATE_____

NAME_____ HOME PHONE _____

WORK PHONE _____ CELL PHONE _____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

AGE_____ BIRTHDATE_____ SOCIAL SECURITY #_____

MARITAL STATUS (circle one) S M D W SEP SEX (circle one) M F

EMAIL ADDRESS _____

OCCUPATION_____ EMPLOYER_____

WORK ADDRESS_____

SPOUSE'S NAME _____ SPOUSE'S CELL PHONE_____

SPOUSE'S EMPLOYER _____ WORK # _____

SPOUSE'S DATE OF BIRTH _____ SOCIAL SECURITY #_____

REFERRING PHYSICIAN OR PERSON _____

PHARMACY NAME_____ PHARMACY #_____

IN CASE OF EMERGENCY:

NEAREST RELATIVE NOT LIVING WITH YOU _____

PERSON'S PHONE_____CELL/WORK_____

RESPONSIBLE PARTY IF NOT PATIENT _____ RELATIONSHIP_____

***** **PLEASE GIVE THE RECEPTIONIST YOUR HEALTH INSURANCE CARD*****

DATE_____ SIGNATURE _____

PATIENT HISTORY

NAME _____ AGE_____ DATE_____

REFERRED BY _____ LAST GYN EXAM _____

LAST MENSTRUAL PERIOD_____

WHAT BRINGS YOU TO THE DOCTOR TODAY? _____

_____

_____FOR HOW LONG?_____

GYNECOLOGY HISTORY

PERIODS BEGAN AGE _____ FLOW (circle one) LIGHT MEDIUM HEAVY LAST#_____DAYS

TIME BETWEEN PERIODS _____ DO YOU HAVE PAIN WITH PERIODS (circle one) Y N

CLOTS (circle one) Y N DO YOU USE TAMPONS/ PADS OR BOTH _____

DO YOU DOUCHE? (circle one) Y N HOW OFTEN _____

MENOPAUSE AGE _____ DO YOU TAKE HORMONES? (circle one) Y N SINCE_____

HAVE YOU HAD A HYSTERECTOMY? (circle one) Y N

WAS YOUR LAST PAP SMEAR NORMAL? (circle one) Y N

IF ABNORMAL, WHAT HAPPENED? _____

LAST MAMMOGRAM _____ WAS IT NORMAL? (circle one) Y N

IF ABNORMAL, WHY? _____

ARE YOU SEXUALLY ACTIVE? (circle one) Y N DO YOU USE CONTRACEPTION NOW? Y N

HAVE YOU EVER BEEN ON THE "PILL"? (circle one) Y N

WHAT BRAND, AND FOR HOW LONG? _____

HAVE YOU EVER HAD ANY SEXUALLY TRANSMITTED DISEASES? (circle one) Y N

IF YES, PLEASE DESCRIBE _____

DO YOU HAVE ANY OF THE FOLLOWING (please circle)?

LOWER BACK PAIN	Y N	VAGINAL DISCHARGE	Y N
LOWER ABDOMINAL PAIN	Y N	VAGINAL IRRITATION	Y N
BURNING WITH URINATION	Y N	LOSS OF URINE WITH COUGH OR SNEEZE	Y N
MORE FREQUENT URINATION	Y N	PRESSURE IN VAGINA	Y N
ABNORMAL BLEEDING BETWEEN PERIODS AFTER INTERCOURSE	Y N Y N Y N	PAIN OR DISCOMFORT WITH INTERCOURSE	Y N

GYN SURGERY

DATE REASON TYPE COMPLICATIONS HOSPITAL

OBSTETRIC HISTORY

TOTAL # PREGNANCIES_____

FULL TERM_____ PREMATURE_____ ABORTIONS/MISCARRIAGES_____ # LIVING CHILDREN_____

DATE TYPE OF DELIVERY WEIGHT BOY/GIRL COMPLICATIONS HOSPITAL

DID YOU HAVE ANY COMPLICATIONS SUCH AS TOXEMIA, DIABETES, EARLY LABOR, INFECTIONS, BLEEDING, FEVER, BLOOD CLOTS? Y N EXPLAIN _____

DID YOU AND YOUR BABY(IES) GO HOME TOGETHER? Y N

ARE CHILDREN HEALTHY NOW? Y N DID YOU HAVE AN EPIDURAL? Y N

PAST MEDICAL HISTORY (circle one)

HEART DISEASE	HIGH BLOOD PRESSURE	ASTHMA	BLEEDING DISORDER
BLOOD CLOTS	DIABETES	KIDNEY DISEASE	SEIZURES
BLADDER INFXNS	HEPATITIS	THYROID DISORDER	STROKE
ULCERS	CANCER	TRANSFUSIONS	MITRAL VALVE
BREAST DISORDER	DEPRESSION	ANXIETY	BOWEL DISORDER
ANEMIA	CHEST PAIN	CONSTIPATION	HEART MURMUR
HEADACHES	SHORTNESS OF BREATH	BRUISING EASILY	PNEUMONIA

PLEASE LIST ALL CURRENT MEDICATIONS (prescription, over the counter, herbal)

MEDICATIONS_____

ARE YOU ALLERGIC TO ANY MEDICINES (Penicillin, Sulfa, other)? Y N Which _____

PAST SURGICAL HISTORY

DATE	TYPE	REASON	COMPLICATIONS	HOSPITAL

HAVE YOU EVER HAD ANY COMPLICATIONS WITH ANESTHESIA? (circle one) Y N

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF CANCER? (circle one) Y N

BREAST CANCER Y N WHICH RELATIVE_____

UTERINE CANCER Y N WHICH RELATIVE_____

OVARIAN CANCER Y N WHICH RELATIVE_____

CERVICAL CANCER Y N WHICH RELATIVE_____

VAGINAL CANCER Y N WHICH RELATIVE_____

ANY OTHER CANCER Y N WHICH RELATIVE_____

WHAT TYPE OF TREATMENTS (CHEMO, RADIATION, SURGERY)?_____

DOES ANYONE IN YOUR FAMILY HAVE: (please circle)

HIGH BLOOD PRESSURE	DIABETES	HEART DISEASE
STROKE	SEIZURES	KIDNEY DISEASE
BLEEDING DISORDER	THYROID DISEASE	OTHER

PLEASE DESCRIBE_____

SOCIAL HISTORY

WHAT IS OCCUPATION?_____

MARITAL STATUS S M D W SEP

DO YOU SMOKE?(circle one) Y N

DO YOU DRINK ALCOHOL? (circle one) Y N _____ounces/week

DO YOU USE DRUGS?(circle one) Y N WHICH? _____

ARE YOU A VICTIM OF DOMESTIC VIOLENCE? (circle one) Y N

IS THERE ANYTHING ELSE YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR? Y N