Genesee Valley Obstetrics & Gynecology, P.C.

Name ______________________________________ Prefer to be called? __________________ Date ________

Reason For Being Seen Today____
Would you like a Chaperone with you during your exam? [] Yes [] No
Primary Care Physician ______________________Date of Last Complete Physical Examination _____________

Family History: Are you adopted? [] Yes [] No

	Name	Age	Health Problems if Alive	If Deceased Cause of Death
Father				
Mother				
Sisters				
Brothers				

Please Mark a (Y) for Yourself or (F) for Family Member

Diabetes		Clotting/Bleeding Problems		Chicken Pox	
High Blood Pressure		Epilepsy		Tuberculosis	
Cancer		Birth Defects		Kidney Disease	
Heart Disease		Inherited Disease		Hepatitis/Liver Disease	
Strokes		Breast Disease		Varicosities/Phlebitis	
Thyroid Problems		History of Blood Transfusion		Asthma	
Infertility		Autoimmune Disorder		Emotional Illness	

Comments: ____
____
____

Medical History: Please Check if You Have or Ever Had the Following

Measles		Difficulty Breathing		Excessive Bleeding w/ Surgery	
German (3 day) Measles		Chronic Lung Disease		Migraine Headaches	
Mumps		Jaundice		Hearing Problems	
Pneumonia		Bowel Problems		Weight Gain/Loss	
Rheumatic fever		Change in Bowel Habits		Kidney or Bladder Infection	
Chest Pain		Blood in Stool		Involuntary Loss of Urine	
X-Rays		Pulmonary Embolus		Pain with Urination	
Changes in Facial/Body Hair		Stomach Problems		Frequent Urge to Urinate	
Hot Flashes		Genital Herpes/Warts		Pressure with Urination	
Other Medical Problems		Gall Bladder Disease		Blood in your Urine	

Comments: ____
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____

Previous Surgery/Hospitalizations

Date	Type of Surgery/Hospitalization	Date	Type of Surgery/Hospitalization

Name:________________________________ Date of Birth:_____________________________________

Present/Past Illnesses or Problems ____
____

Medication Allergies: ____
Other Allergies: ____
Medications You Take: ____
____

Do you smoke? [] Yes [] No How Much?_____________ How Long? ________________
Do you drink alcohol? [] Yes [] No How Much? _______________________________________
Do you drink caffeine? [] Yes [] No How Much? _______________________________________
Do you use marijuana,
cocaine or other street drugs? [] Yes [] No Explain ____
Do you exercise? [] Yes [] No How Much? ______________ What Type? _______________
Do you wear a seat belt? [] Yes [] No
Do you eat a well balanced diet? [] Yes [] No
Do you take Calcium/Vitamin D supplements? [] Yes [] No
Do you see a dentist on a regular basis? [] Yes [] No
Are your immunizations current? [] Yes [] No
Have you had a colonoscopy? [] Yes [] No If yes, when? _________________________
Have you had a DEXA scan? [] Yes [] No If yes, when? _________________________
Have you had your cholesterol measured? [] Yes [] No If yes, when? _________________________
Do you have a Health Care Proxy? [] Yes [] No
Are there any social/family issues that cause worry or concern for you? [] Yes [] No
Do you feel you have experienced physical, emotional, sexual or verbal abuse? [] Yes [] No

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Gynecological History:

Age when periods began ____ First day of last period __________ How often do you have a period __________
Are you bothered by: [] Heavy Bleeding [] Clots [] Cramping [] Bloating [] Mood Changes [] Irregular Bleeding
Do you have a history of abnormal pap smears? [] Yes [] No
Have you had a pap smear in the last three years? [] Yes [] No If no, when was last pap smear? _______________
Did your mother take DES or any hormone when pregnant with you? [] Yes [] No
Are you having, or have had, intercourse? [] Yes [] No If yes, age you became sexually active _______
Are you sexually active with: [] Males [] Females [] Both
Are you using birth control? [] Yes [] No If Yes, What Method of Birth Control ________________________
Are you using condoms? [] Yes [] No
Are you concerned you may have been exposed to any sexually transmitted diseases? [] Yes [] No
Do you have any problems or pain with intercourse? [] Yes [] No
Do you perform self breast exams monthly? [] Yes [] No
Have you ever had a Mammogram? [] Yes [] No If yes, When / Where? ________________________________

Pregnancies:

Any Problems Becoming Pregnant? [] Yes [] No If yes, explain _______________________________________

List Deliveries:

Date	Type of Delivery	Sex	Birth Weight	Health	Name

Number of living children _____ Any congenital defects? ____
Any complications with pregnancies? ____
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Reviewed With Patient _________________________________
Sign and Date