Abington Jefferson Health

PATIENT NAME_____

D.O.B.: _____

Reason for today's visit ☐Annual ☐Problem

Describe problem or list topics you want to discuss:

_____

_____

_____

Current Medications, Vitamins, Herbal Supplements:

_____

_____

_____

_____

Allergies to Medications or Latex & Type of Reaction**:**

_____

_____

_____

Past Medical History: List medical and health problems:

_____

_____

_____

Family Medical History: (write in which family members)

- ☐ High Blood Pressure _____
- ☐ Heart Disease _____
- ☐ Diabetes _____
- ☐ Stroke _____
- ☐ Breast Cancer _____
- ☐ Ovarian Cancer _____
- ☐ Colon Cancer _____
- ☐ Depression _____
- ☐ Drinking or Drug Problem _____
- ☐ Other _____

_____

List Hospitalization or Surgeries – what year was it?

_____

_____

_____

Review of Systems – List symptoms or problem with:

Head, eyes, ears, nose, or throat:

Heart & Lungs:

Gastrointestinal:

Genital-Urinary:

Neurological, muscular, orthopedic:

GYN History: Date of 1st day of LAST PERIOD_____

OR date of MENOPAUSE_____

OR date of HYSTERECTOMY_____

How old were you when you started your periods?_____

How far apart are your periods?_____

How many days do you bleed?_____

Bleeding is? ☐Light ☐Medium ☐Heavy ☐Flooding

Cramps? ☐None ☐Mild ☐Moderate ☐Severe

Type of Birth Control you use?_____

(Tubal/Vasectomy/Condoms/Pill/Patch/Ring/Diaphragm/Injection/IUD)

Prior Pap Test Results: ☐Normal ☐Abnormal ☐None

Date of Last Pap Smear:_____

Date of Last Mammogram: _____ ☐Normal ☐Abnormal

Date of Last Bone Density: _____ ☐Normal ☐Abnormal

Any history of sexually transmitted infections? _____

Type:_____

Obstetrical History:

#_____Full-Term Pregnancies

#_____Pre-term Pregnancies

#_____Miscarriages

#_____Terminations/Abortion

#_____Tubal-Ectopic Pregnancy

#_____Living Children

Type of Delivery:

_____Vaginal

_____Forceps/Vacuum

_____ C-Sections

_____ VBAC

Any complications? _____

_____

_____

Social History:

Occupation:_____ #_____hours/week

Student? ☐No ☐Yes

Grade or Year: _____ Major:_____

Smoking? ☐No ☐Yes #_____pack(s) per day? ☐Never

Alcohol? ☐No ☐Yes #_____drinks per day/week/month

Drugs? ☐No ☐Yes Type: _____

Exercise? ☐No ☐Yes #_____ days per week

☐Aerobic ☐Weight Bearing & Resistance

Sleep: ☐Good ☐Problem ☐Taking Sleep Aid

Relationship status:

☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Sexuality: ☐Male Partner ☐Female Partner

Sexual History: ☐Active ☐Inactive

Libido (sex drive): ☐Good ☐Average ☐Poor

Psychiatric History: ☐None

☐Depression ☐Anxiety ☐Substance Abuse ☐Other

Abuse & Violence: Are you *currently* in a situation where you are physically, emotionally, or sexually abused? ☐Yes ☐No

Have you *ever* been in a situation where you were physically, emotionally, or sexually abused? ☐Yes ☐No

Patient Name: _____

Phone Number:_____

Signature:_____**Date:**_____