# Western OB/GYN, A Division of Ridgeview Clinics
# Patient History Information

Patient Name_____ DOB_____ Age _____Today's Date_____

Occupation: _____Preferred Pharmacy/Location: _____

**REASON FOR TODAY'S VISIT:** _____
**OR Please Check One↓**
**Annual Complete Physical Exam**_____(please check insurance for coverage) **Breast & Pelvic Exam (Medicare Only)** _____

**ALLERGIES:** Medication_____ Other Allergies_____

**CURRENT MEDICATIONS**: (include all prescription meds, vitamins & over-the-counter meds)_____
_____

**MEDICAL HISTORY:** _____

**SURGICAL HISTORY:** _____

**Family History:** Are you adopted? ___Yes ___No
Please indicate which family members have a history of the following medical conditions using **F**(Father), **M**(Mother),**B**(Brother), **S**(Sister), **MGM** (maternal grandmother), **MGF** (maternal grandfather), **PGM** (paternal grandmother), **PGF** (paternal grandfather)

| | | |
|---|---|---|
| Diabetes | Anesthesia problems | Ovarian cancer |
| Heart disease | Drug/Alcohol problems | Blood clots |
| Stroke (before age 50) | Osteoporosis | Other cancers (list location in body) |
| High cholesterol | Depression | |
| Bleeding problems | Breast cancer | |

**Are you <u>currently</u> having <u>significant</u> problems with:** (Please "x" all that apply):

| | | |
|---|---|---|
| ☐ Fatigue ☐ Fevers<br>☐ Chills ☐ Loss of appetite | ☐ Visual changes | ☐ Headaches |
| ☐ Breast lumps<br>☐ Breast tenderness<br>☐ Nipple discharge | ☐ Chest pain<br>☐ Palpitations | ☐ Shortness of breath<br>☐ Wheezing<br>☐ Cough |
| ☐ Nausea<br>☐ Vomiting<br>☐ Diarrhea<br>☐ Constipation<br>☐ Abdominal pain | ☐ Frequent urination<br>☐ Burning with urination<br>☐ Blood in urine<br>☐ Urinary leakage<br>☐ Painful periods | ☐ New skin lesions<br>☐ Change in existing skin lesions |
| ☐ Heat intolerance<br>☐ Acne<br>☐ Abnormal hair growth | ☐ Anxiety<br>☐ Depression<br>☐ Difficulty sleeping | |

**Menstrual History**

| | | |
|---|---|---|
| Age period began | # of days between periods | # of days of flow |
| # pads/tampons saturated on heaviest day | Bleeding between periods | Problems with menstruation |
| Cramps ***(circle)*** mild/moderate/severe | Date of last menstrual period | Age of menopause |

**Obstetrical History:**

| | | |
|---|---|---|
| Total # of pregnancies | # Full-term pregnancies | # Miscarriages |
| # Premature deliveries | # Elective abortions | # Living children |

**Continue on back of page**

**Gynecological History:**

| | | |
|---|---|---|
| Do you have sex with (circle)?: Men Women Both None | | Any problems with sexual relations: |
| Abnormal pap smear Date Treatment | | Do you have any concerns of being exposed to HIV/STD's? |
| ***Circle*** any previous infections: Chlamydia Gonorrhea Syphilis Trichomonus Bacterial vaginosis Condylomata (genital warts) Herpes Other | | |

**If you are between the ages of 16-26 and are sexually active,** CDC recommends routine screening for Chlamydia annually (can occur without symptoms). Please answer the following questions:
I have had a negative test within the last year ____ Yes _____ No
I would like to be tested for chlamydia ____ Yes _____ No

**Birth Control History:**

| | |
|---|---|
| Are you currently using birth control: _____ Yes _____ No | Current method: |
| ***Circle*** all methods you have ever used: None Vasectomy Diaphragm Tubal ligation Pill DepoProvera IUD Implants Rhythm Condom Spermicides Patch NuvaRing Other: | |

**Social History: Single Married Divorced Widowed (Circle one)**

| | | |
|---|---|---|
| Regular exercise: ____Yes_____No Amount per week: | Wear seatbelts: ____Yes_____No | Do you skip meals: _____Yes_____No |
| Have you ever been sexually, physically or emotionally abused? | If yes, is this abuse going on now? | Do you drink alcohol? Type: Amount per week: |
| Tobacco use: Are you interested in quitting? | Drug use: _____Yes_____No | |

**Alcohol assessment:**

| | |
|---|---|
| Have you ever felt you ought to cut down on your drinking? | Yes ___ No ___ |
| Have you ever had people annoy you by criticizing your drinking? | Yes ___ No ___ |
| Have you ever felt bad or guilty about your drinking? | Yes ___ No ___ |
| Have you ever had a drink as an eye opener first thing in the morning to steady your nerves, or get rid of a hangover, or to get your day started? | Yes ___ No ___ |

**Colon cancer screening for women 50 and older:**

| | |
|---|---|
| I have performed 3 Hemoccult cards in the last year | ____Yes ____ No ____Unsure |
| I have had a flexible sigmoidoscopy or Barium enema x-ray in the past 5 years | ____Yes ____ No ____Unsure |
| I have had a colonoscopy in the past 10 years | ____Yes ____ No ____Unsure |

**If yes, month and year**_____
Clinic/Physician name where test was done _____

**Bone densitometry Screening**

| | |
|---|---|
| Have you had this screening done in the past | ____Yes ___ No ___ Unsure |
| When were you screened: | Month _____ Year _____ |

**Optional:** List the name of an individual authorized to discuss your medical condition, treatment, or billing: _____ (i.e. spouse, parent, other). From: (today's date)_____
To: (one year from today)_____. Patient signature:_____
Date:_____ Note: Parent/Guardian must sign if patient is under 18, unless emancipated.

**Email Address:**_____

**Reviewed by provider: Initial _____ Date _____**