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

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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:
On more than 2 occasions in the past year, have you had 4 or more alcoholic beverages in a day? 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 _____