NAME: _____**DATE OF BIRTH**: _____/_____/_____**AGE**:_____
FIRST MIDDLE INITIAL LAST

TODAYS DATE: ____/___/____**REASON FOR VISIT**: _____

HAVE YOU EVER HAD OR DO YOU HAVE:

	YES	NO		YES	NO
Alcoholism			Hepatitis		
Anemia			High Blood Pressure		
Angina/Heart Attack			HIV/AIDS		
Arthritis			Kidney Disease		
Asthma			Liver Problems		
Birth Defects			Lung Problems		
Bladder Disease			Mental Illness		
Bleeding Disorder			Sexually Transmitted Diseases		
Cancer:			Sexual Abuse		
Diabetes			Stroke		
Emphysema			Suicidal		
Epilepsy/Seizures			Tuberculosis – TB		
Glaucoma			Thyroid Problem		
Headaches			Other:		
Heart Failure					

PLEASE LIST ANY SURGERIES YOU HAVE HAD:

SURGERY/REASON	DATE	SURGERY/REASON	DATE

PLEASE LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

DRUG NAME	DOSAGE	PHYSICIAN	DRUG NAME	DOSAGE	PHYSICIAN

ALLERGIES TO MEDICATIONS/LATEX GLOVES – PLEASE LIST BELOW:

1.) _____ 3.) _____ 5.) _____

2.) _____ 4.) _____ _____ No Known Allergies

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Harrisonburg OBGYN

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Danielle Wells, FNP | Shannon Ikenberry, WHNP | Anastasia Suslaev, CNM

CIRCLE AND CHECK IF ANY BLOOD RELATIVE(S) CURRENTLY HAS OR HAS HAD:

MAJOR ILLNESSES	YES	NO	WHAT BLOOD RELATIVE(S)	AGE AT ONSET
Alcoholism				
Anemia				
Angina/Heart Attack				
Birth Defects				
MAJOR ILLNESS	**YES**	**NO**	**WHAT BLOOD RELATIVE(S)**	**AGE AT ONSET**
Bladder Disease				
Bleeding Disorder				
Breast Cancer				
Colon Cancer				
Diabetes				
Emphysema				
Epilepsy or Seizures				
Glaucoma				
GYN Cancer				
Headaches/Migraines (circle one)				
Heart Failure				
Hepatitis				
High Blood Pressure				
HIV/AIDS				
Kidney Disease/Stones				
Liver Problems				
Lung Problems				
Mental Illness				
Stroke				
Thyroid Problems				
Tuberculosis – TB				
Venereal Disease/STD				
Other:				
None of the above				

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YOUR GYN HISTORY

What age did you have your first period?	
How many days are there from start of period to the start of your next period? _____days	
How long does your period last? _____days	Flow: Light Medium Heavy
Number of tampons per day:	Number of pads per day:
First day of your last period:	What do you use for birth control?
Do you have clots? ☐Yes ☐No	Do you have bleeding in between periods? ☐Yes ☐No
Have you gone through Menopause?	If so at what age:
Are you on Hormone Replacement Therapy? ☐Yes ☐No	
When was your last Pap Smear:	Was it normal? ☐Yes ☐No Any abnormal Pap Smears? ☐Yes ☐No
When was your last Mammogram:	Was it normal? ☐Yes ☐No Any abnormal Mammograms? ☐Yes ☐No

YOUR OB HISTORY

	NUMBER		NUMBER
Total # of pregnancies		Full term births	
Premature		Abortion induced	
Miscarriages		Living children	

In the section below, please fill in answers for each pregnancy including abortions and miscarriages.
IF YOU HAVE HAD A TUBAL LIGATION, HYSTERECTOMY OR ARE POSTMENOPAUSAL YOU MAY SKIP TO THE NEXT SECTION

Delivery #	Birth Date	Weeks Gestation	Labor Hours	Sex	Baby's Weight	Delivery Type	Anesthesia	Any Early Labor?	Approx. Weight Gain	Complications	Location
1.)											
2.)											
3.)											
4.)											
5.)											
6.)											

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SOCIAL HISTORY

PLEASE LIST HABITS
Are you sexually active? ☐Yes ☐No How many sexual partner do you currently have?
How many partners have you had in the last year?
Any bleeding after intercourse? ☐Yes ☐No Any pain after intercourse? ☐Yes ☐No
Do you exercise? ☐None ☐Less than 3 times per week ☐ More than 3 times per week ☐Active with no formal exercise
Tobacco Do you smoke? ☐Yes ☐No Packs per day: Number of years:
Alcohol Do you drink alcohol? ☐Yes ☐No How many drinks per day/week?
Drugs Are you a drug user? ☐Yes ☐No Kind of drug(s) used: Frequency:
History of Abuse Do you have a history of abuse?☐Yes ☐No If so, please check all that apply: ☐Physical ☐Emotional ☐Sexual

Please check if any of the following applies to you now

Body aches		**EYES**	
Night sweats		Visual changes	
Weight loss		Blurred vision	
GASTROINTESTINAL		Sensitivity to light	
Constipation		**PSYCHIATRIC**	
Diarrhea		Mood swings	
Abdominal pain		Trouble sleeping	
Reflux		Anxiety	
Blood in stools		**HEMATOLOGIC**	
Vomiting		Easy bleeding	
GENITOURINARY		Easy bruising	
Leaking of urine with cough, sneezing,		Lymph node enlargement	
Urinating at night		**HENT**	
Pain when urinating		Headaches	
Vaginal dryness		Neck stiffness	
RESPIRATORY		**BREAST**	
Cough		Lumps	
Shortness of breath while sitting		Tenderness	
ENDOCRINE		Nipple discharge	
Frequent urination		**INTEGUMENTARY**	
Hair growth/loss		Rash	
Cold intolerance		**OTHER:**	
Heat intolerance			
Hot flashes			

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