M. Catherine Slusher, MD
Stephanie Scheidt, MD
Jamie Boykin, CNM
LaDene King, MD
Daniel Weinberg, MD
Shannon Ikenberry, WHNP
Whitney Adams, CNM
Bryan Maxwell, DO
Sherry Mongold, FNP
Eleanor Colmenares, CNM

NAME: ____ DATE OF BIRTH: ____/____/____

AGE: _____ EMAIL: ____________________________________

PREFERRED PHARMACY: ____

ALLERGIES TO MEDICATIONS/ LATEX GLOVES – PLEASE LIST BELOW & INCLUDE REACTION:

1.
2.
3.
4.
5. ___________________
6. NO KNOWN ALLERGIES: ______

CURRENT MEDICATIONS (PRESCRIPTIONS AND OVER-THE-COUNTER):

DRUG NAME	DOSAGE	PHYSICIAN	DRUG NAME	DOSAGE	PHYSICIAN
1.			**6.**		
2.			**7.**		
3.			**8.**		
4.			**9.**		
5.			**10.**		

GYNECOLOGICAL HISTORY:

Date of Last Menstrual Cycle: Current Birth Control:
Length of Menstrual Cycle? _______ days Date of Last PAP Smear:
History of Abnormal PAP Smear? YES / NO If yes, When?
Have you had the HPV Vaccine? ☐ Completed ☐ Not Completed ☐ No
History of Sexually Transmitted Infection? YES / NO If Yes, which STI?
When was your last Mammogram? ____/____/____ Was it normal? ☐ Yes ☐ No
When was your last Colonoscopy? ___/___/____ When was your last Bone Density test? ___/___/____
Date of last Cholesterol screening ___/___/____ Date of last Diabetes screening: ___/___/____
Have you gone through Menopause? ☐ Yes ☐ No If Yes, what age? ______
Sexual orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgender ☐ Prefer not to disclose
At what age did you have your first period?
Have you gone through Menopause? ☐ Yes ☐ No If so what age? ______

GYNECOLOGICAL HISTORY (continued):

History of any of the following (please circle)?

Endometriosis: YES / NO
Fibroids: YES / NO
Infertility: YES / NO
Recurrent Ovarian Cysts: YES / NO
PCOS: YES / NO
Dysmenorrhea (painful periods): YES / NO
HIV Positive: YES / NO

OBSTETRICAL HISTORY:

	NUMBER		NUMBER
Total # of pregnancies		Full-term Births	
Premature Births		Abortions induced	
Miscarriages		Living children	
Ectopic Pregnancies		Multiple Births	

PAST PREGNANCIES:

1.	Date of Birth: Weight: Gender: Gestational Age of Delivery: Vaginal Delivery or Cesarean Delivery: Hospital/ Delivering Provider: Complications in Pregnancy/ After Delivery? YES / NO If yes, please list:
2.	Date of Birth: Weight: Gender: Gestational Age of Delivery: Vaginal Delivery or Cesarean Delivery: Hospital/ Delivering Provider: Complications in Pregnancy/ After Delivery? YES / NO If yes, please list:
3.	Date of Birth: Weight: Gender: Gestational Age of Delivery: Vaginal Delivery or Cesarean Delivery: Hospital/ Delivering Provider: Complications in Pregnancy/ After Delivery? YES / NO If yes, please list:

4.	Date of Birth: Weight: Gender: Gestational Age of Delivery: Vaginal Delivery or Cesarean Delivery: Hospital/ Delivering Provider: Complications in Pregnancy/ After Delivery? YES / NO If yes, please list:

FAMILY HISTORY:

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

MAJOR ILLNESSES	YES	NO	WHAT BLOOD RELATIVE(S) (INCLUE MATERNAL OR PATERNAL)	AGE AT ONSET
Alcoholism				
Anemia Angina/ Heart Attack				
Angina/Heart Attack				
Birth Defects				
Bladder Disease				
Bleeding Disorder				
Breast Cancer				
Colon Cancer				
Diabetes				
Emphysema				
Epilepsy or Seizures				
Glaucoma				
Cervical Cancer				
Ovarian Cancer				
Headache or Migraine (circle one)				
Heart Failure				
Hepatitis				
High Blood Pressure				
HIV/AIDS				
Kidney Disease/Stones				
Liver Problems				
Lung Problems				
Stroke				
Thyroid Problems				
Tuberculosis - TB				
Venereal Disease/STD				
Other:				
None of the above				

YOUR SOCIAL HISTORY:

What is your relationship status?
Are you sexually active? YES / NO
What is your ethnic background?
Do you have a history of domestic violence? ☐ Yes ☐ No If so, please check all that apply: ☐ Physical ☐ Emotional ☐ Sexual
What is the highest level of education you have completed?
Are you currently in school? ☐ Yes ☐ No If so, where do you attend school?
Are you currently employed? ☐ Yes ☐ No If so, where do you work?
Do you have an advance directive? ☐ Yes ☐ No
Is blood transfusion acceptable in an emergency? ☐ Yes ☐ No
What is you exercise level? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy How many times a week do you exercise? ☐1-2 ☐3-4 ☐5-7
Do you or have you ever smoked tobacco? ☐ Never Smoker ☐ Former Smoker ☐ Current every day smoker ☐ Current some days smoker If so, how many packs per day: Number of years: Are you interested in quitting?
Do you consume alcohol? If yes, how often? ______ drinks per day _________ drinks per week
Illicit or recreational drug use? YES / NO If yes, what substance and how often?
Do you consume caffeine? YES / NO

PLEASE LIST ANY SURGERIES YOU HAVE HAD:

SURGERY/REASON	HOSPITAL/ OFFICE LOCATION	DATE
1.		
2.		
3.		
4.		
5.		

YOUR PAST MEDICAL HISTORY:

	YES	NO		YES	NO
Cancer			Heart Arrythmia		
Blood in Urine			Recurrent UTI		
Heart Disease			High Blood Pressure		
High Cholesterol			Pre-Eclampsia		
Acne			Eczema/ Psoriasis		
Hearing Loss			Seasonal Allergies		
Diabetes			Gestational Diabetes		
Thyroid Problems			Osteopenia		
Osteoporosis			Prolactinoma		
Vitamin Deficiency			Glaucoma		
Vision Loss/ Macular Degeneration			Colon Polyps		
Crohn's/ Ulcerative Colitis			Gallbladder disease		
Hemorrhoids			Irritable Bowel Syndrome		
Liver Problems/ Hepatitis			Reflux/ Ulcers		
Dysplasia			Endometriosis		
Fibroids			Infertility		
PCOS			Anemia		
Bleeding Disorder			Blood Clotting Disorder		
Blood Transfusion			DVT/ Pulmonary Embolism		
Chicken Pox/ Shingles			HIV/ AIDS		
Herpes			MRSA		
Tuberculosis			Renal Disease		
Dementia			Headaches		
Migraines			Multiple Sclerosis		
Epilepsy/ Seizures			Stroke		
Arthritis			Chronic Back Pain		
Fractures			ADD		
Anxiety			Bipolar Disorder		
Depression			Eating Disorder		
Asthma			COPD/ Emphysema		
Sleep Apnea			Autoimmune Disease		
Kidney Stones			Urinary Incontinence		
Aneurysm			Other:		

Our office strives to provide prompt responses, appointments, and results. We strongly recommend setting up a patient portal account. If you have any questions or concerns, please speak to office staff prior to your check out today.

2291 Evelyn Byrd Avenue
Harrisonburg, Virginia 22801
540.434.3831
www.harrisonburgobgyn.com