



M. Catherine Slusher, MD
Bryan Maxwell, DO
Danielle Wells, FNP

Michael Botticelli, MD
Stephanie Scheidt, MD
Shannon Ikenberry, WHNP

LaDene King, MD
Sherry Mongold, FNP
Anastasia Suslaev, CNM

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

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



M. Catherine Slusher, MD
Bryan Maxwell, DO
Danielle Wells, FNP

Michael Botticelli, MD
Stephanie Scheidt, MD
Shannon Ikenberry, WHNP

LaDene King, MD
Sherry Mongold, FNP
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				

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



M. Catherine Slusher, MD
Bryan Maxwell, DO
Danielle Wells, FNP

Michael Botticelli, MD
Stephanie Scheidt, MD
Shannon Ikenberry, WHNP

LaDene King, MD
Sherry Mongold, FNP
Anastasia Suslaev, CNM

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have bleeding in between periods? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you gone through Menopause?	If so at what age:
Are you on Hormone Replacement Therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
When was your last Pap Smear:	Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No Any abnormal Pap Smears? <input type="checkbox"/> Yes <input type="checkbox"/> No
When was your last Mammogram:	Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No Any abnormal Mammograms? <input type="checkbox"/> Yes <input type="checkbox"/> 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.)											



M. Catherine Slusher, MD
 Bryan Maxwell, DO
 Danielle Wells, FNP

Michael Botticelli, MD
 Stephanie Scheidt, MD
 Shannon Ikenberry, WHNP

LaDene King, MD
 Sherry Mongold, FNP
 Anastasia Suslaev, CNM

SOCIAL HISTORY

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