

Brunswick-Hills OB/GYN

ANNUAL EXAM

Patient ID# _____

Date of Visit: _____

Name _____ Age _____ Date of Birth _____

Family Doctor _____ Other treating physicians _____

PERSONAL HISTORY

ALLERGIES: _____

ALL MEDICATIONS (dose & frequency) _____

SOCIAL HISTORY: Marital Status: Single Married Widow Divorced **Occupation:** _____

Are you sexually active? Yes ___ No ___

Do you have pain with intercourse? Yes ___ No ___

Have you ever been sexually abused or assaulted? Yes ___ No ___

Do you perform monthly self breast examinations? Yes ___ No ___

Do you exercise? Yes ___ No ___ Number of times per week _____ Type of exercise _____

Diet: Healthy ___ Unhealthy ___ Diet Program _____

Are you experiencing any stress issues: Yes ___ No ___ Type of Stress _____

Have you had any major life changes? Yes ___ No ___ Explain: _____

Living Will? Yes ___ No ___ Power of Attorney for healthcare? Yes ___ No ___

| | | | | |
|---------|--------------|------------|---------------|----------------------------|
| HABITS: | SMOKER | PAST _____ | PRESENT _____ | AMOUNT _____ |
| | ALCOHOL | NONE _____ | MINIMAL _____ | MODERATE _____ HEAVY _____ |
| | CAFFEINE | NONE _____ | MINIMAL _____ | MODERATE _____ HEAVY _____ |
| | STREET DRUGS | PAST _____ | PRESENT _____ | AMOUNT/TYPE _____ |

MEDICAL HISTORY: SINCE YOUR LAST EXAM, HAVE YOU HAD ANY PROBLEMS WITH:

- | | | |
|---|--|---|
| <input type="checkbox"/> Abnormal pap smear | <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Anesthesia reaction | <input type="checkbox"/> Anxiety/emotional disorder | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Breast problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Chronic lung condition |
| <input type="checkbox"/> Cysts | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Herpes | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Intestinal problems | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Lupus/Autoimmune disorders | <input type="checkbox"/> Recurrent vaginitis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Sexually transmitted diseases | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Transfusions | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Urinary problems | | |

OTHER _____

GYN HISTORY:

Last Menstrual Period _____ Duration _____ Frequency _____

Flow: Regular _____ Irregular _____ Moderate _____ Light _____

Contraceptives: present – pills/patch/injection diaphragm condoms tubal vasectomy other _____

Infertility – How long have you been attempting pregnancy? _____

DATE and RESULTS of last: Pap Smear _____

Mammography _____

Dexascan _____

Colonoscopy _____

Blood work _____

DO NOT WRITE BELOW HERE:

WT: _____

HT: _____

BP: _____

LMP _____

MEDS _____

Patient requests an assistant in room

Patient initials: YES _____ NO _____

Assistant initials _____