

WENDOVER OB/GYN & INFERTILITY, INC.

Name _____ Date of Birth _____ Today's Date _____

PROBLEMS OR SYMPTOMS

In the lines below, please describe any special problems or symptoms you would like to discuss with the doctor today:

How long have you had this problem? _____

Have you ever seen a doctor for this problem in the past? YES NO

If yes, what was the diagnosis? _____

How was the problem treated? _____

Did this treatment help you? _____

Preferred Pharmacy: _____ Location: _____

GYNECOLOGICAL HISTORY

Age menstrual period began _____

Are your menstrual periods regular? YES NO

Is your flow Heavy Medium Light

Do you have vaginal bleeding between your menstrual periods? YES NO

Date of last pap test _____

Have you ever had an abnormal pap test YES NO

If yes, when _____

How treated? _____

Did your mother take DES while pregnant with you?

YES NO

Do you have: _____

Pain with intercourse? YES NO

Sexual difficulties YES NO

Vaginal itching? YES NO

Heavy or abnormal vaginal discharge? YES NO

Have you ever had a mammography? YES NO

If yes, when? _____

Have you ever had trouble getting pregnant? YES NO

Do you have hot flashes? YES NO

Date of last menstrual period _____

How many days do you flow? _____

Do you have pain or cramps? YES NO

How often do your periods occur? every 28 days other _____ days

Do you take birth control pills? YES NO

If yes, how long have you taken them? _____

Other means of contraception if not birth control pills?

IUD Diaphragm Condoms Withdrawal Rhythm

Other _____

Do you have trouble with urination? YES NO

Do you leak urine when coughing or sneezing? YES NO

Do you have burning with urination? YES NO

Do you have to get up at night to urinate? YES NO

Do you have trouble getting to the bathroom on time? YES NO

Have you ever had a hemocult stool testing? YES NO

If yes, when? _____

Do you examine your breasts each month? YES NO

Have you noticed any lumps or nipple discharge? YES NO

PREGNANCIES

How many times have you been pregnant? _____

How many pregnancies did you carry to term? _____

Miscarriages? _____

How many abortions? _____

How many ectopics? _____

How many premature births? _____

How many stillborn babies? _____

Twins or multiple births? _____

How many Caesarean sections? _____

How many children do you have living? _____

Any adopted children? _____

Age of youngest child? _____

continued on back

GENERAL SCREEN

Please the following problems that you have **RIGHT NOW**.

- | | | |
|---|---|--|
| 1. <input type="checkbox"/> UNEXPLAINED weight change
<input type="checkbox"/> Fever
10) <input type="checkbox"/> Dizzy spells/fainting
2. <input type="checkbox"/> Trouble with eyes
3. <input type="checkbox"/> Trouble with ears or hearing
<input type="checkbox"/> Nose bleeds
<input type="checkbox"/> Trouble with nose/sinus
4. <input type="checkbox"/> Chest pain
<input type="checkbox"/> Irregular Heartbeat
5. <input type="checkbox"/> Coughing up a lot of phlegm
<input type="checkbox"/> Coughing spells
<input type="checkbox"/> Shortness of breath
6. <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Constipation
<input type="checkbox"/> Blood in stools
<input type="checkbox"/> Heartburn/indigestion
<input type="checkbox"/> Recurrent diarrhea
7. <input type="checkbox"/> Pain or bleeding w/ intercourse
<input type="checkbox"/> Abnormal vaginal discharge
<input type="checkbox"/> Vaginal itching or odor
<input type="checkbox"/> Abnormal vaginal bleeding
<input type="checkbox"/> Leaking urine
<input type="checkbox"/> Painful urination
8. <input type="checkbox"/> Severe joint/muscle pain
9. <input type="checkbox"/> Changes in skin lesions (wart, moles)
<input type="checkbox"/> Breast pain | <input type="checkbox"/> Breast lump
<input type="checkbox"/> Nipple discharge not associated w/pregnancy
10. <input type="checkbox"/> Migraine headaches
<input type="checkbox"/> Awaken with headaches
<input type="checkbox"/> Trouble with balance
11. <input type="checkbox"/> Work/family problems
<input type="checkbox"/> Domestic violence
<input type="checkbox"/> History of sexual assault
12. <input type="checkbox"/> Hot flashes
<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Diabetes
13. <input type="checkbox"/> Unexplained bruising
<input type="checkbox"/> Bleeding from gums |
|---|---|--|

Have you ever had any discharge from your breasts when not pregnant? _____ YES NO

Are you ALLERGIC to any medications, foods or other substances? _____ YES NO

If yes, what? _____

List all medications you are currently taking: _____

Have you ever used marijuana or heroin, LSD, cocaine, or similar drugs? _____ YES NO

Have you ever considered committing suicide? _____ YES NO

When is the last time you had a physical examination? _____

Have you ever been told you had any chronic or serious illness? _____ YES NO

Have you ever been hospitalized other than pregnancy? If so list:

Operation or illness	Month and Year	City and State
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do any of your blood relatives have:

- | | | | | |
|---|------------------------------|-----------------------------|------------------------|---------------------|
| Diabetes?..... | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Who? _____ | Age at onset? _____ |
| Heart Disease? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Who? _____ | Age at onset? _____ |
| Heart Attacks? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Who? _____ | Age at onset? _____ |
| High Blood Pressure? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Who? _____ | Age at onset? _____ |
| Cancer of the breast? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Who? _____ | Age at onset? _____ |
| Birth defects or mental retardation? .. | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Who? _____ | Age at onset? _____ |
| Cancer? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Who? _____ Type? _____ | Age at onset? _____ |

COMMENTS:

Check any of the following problems that you have had. If RECENT, give date or year.

- | | | |
|--|--|--|
| <input type="checkbox"/> German measles
<input type="checkbox"/> kidney or bladder infection
<input type="checkbox"/> venereal disease
<input type="checkbox"/> female (pelvic) disorders
<input type="checkbox"/> lumps in breast
<input type="checkbox"/> mental disease
<input type="checkbox"/> skin tumors
<input type="checkbox"/> asthma | <input type="checkbox"/> scarlet fever
<input type="checkbox"/> rheumatic fever
<input type="checkbox"/> jaundice
<input type="checkbox"/> diabetes (sugar)
<input type="checkbox"/> blood transfusions
<input type="checkbox"/> heart disease/murmur
<input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> tuberculosis
<input type="checkbox"/> hepatitis
<input type="checkbox"/> thyroid
<input type="checkbox"/> phlebitis (blood clots in legs)
<input type="checkbox"/> epilepsy (seizures, fits)
<input type="checkbox"/> ulcers
<input type="checkbox"/> hemorrhoids |
|--|--|--|

Do you smoke? YES NO If yes, how many packs per day? _____

How long have you smoked? _____ Years _____ Months

Do you drink alcohol socially? YES NO

Do you drink coffee? YES NO If yes, how many cups per day? _____

Do you exercise regularly? YES NO