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? _____

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GENERAL SCREEN

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

1. ❑ UNEXPLAINED weight change
   ❑ Fever
10) ❑ Dizzy spells/fainting
2. ❑ Trouble with eyes
3. ❑ Trouble with ears or hearing
   ❑ Nose bleeds
   ❑ Trouble with nose/sinus
4. ❑ Chest pain
   ❑ Irregular Heartbeat
5. ❑ Coughing up a lot of phlegm
   ❑ Coughing spells
   ❑ Shortness of breath
6. ❑ Nausea or vomiting
   ❑ Constipation
   ❑ Blood in stools
   ❑ Heartburn/indigestion
   ❑ Recurrent diarrhea
7. ❑ Pain or bleeding w/ intercourse
   ❑ Abnormal vaginal discharge
   ❑ Vaginal itching or odor
   ❑ Abnormal vaginal bleeding
   ❑ Leaking urine
   ❑ Painful urination
8. ❑ Severe joint/muscle pain
9. ❑ Changes in skin lesions (wart, moles)
   ❑ Breast pain
   ❑ Breast lump
   ❑ Nipple discharge not associated w/pregnancy
10. ❑ Migraine headaches
    ❑ Awaken with headaches
    ❑ Trouble with balance
11. ❑ Work/family problems
    ❑ Domestic violence
    ❑ History of sexual assault
12. ❑ Hot flashes
    ❑ Thyroid disease
    ❑ Diabetes
13. ❑ Unexplained bruising
    ❑ 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 commiting 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? ..... ❑ YES ❑ NO Who? _____ Age at onset? _____
Heart Disease? ..... ❑ YES ❑ NO Who? _____ Age at onset? _____
Heart Attacks? ..... ❑ YES ❑ NO Who? _____ Age at onset? _____
High Blood Pressure? ..... ❑ YES ❑ NO Who? _____ Age at onset? _____
Cancer of the breast? ..... ❑ YES ❑ NO Who? _____ Age at onset? _____
Birth defects or mental retardation? . ❑ YES ❑ NO Who? _____ Age at onset? _____
Cancer? ..... ❑ YES ❑ NO Who? _____ Type? _____ Age at onset? _____

COMMENTS:

_____
_____

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

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