Gynecological Patient Information

Welcome to our practice - we are glad you are here!

Appointment Date: ____________ **Appointment with** (Doctor or Midwife): ____________

Name: ____________ **Date of Birth:** ____________

Have you ever been pregnant? **Yes** ◯ **No** ◯ **How many times:** ____________

Number of Miscarriages: ____________ Number of Terminations: ____________ Number of Living Children: ______

Date of last Menstrual Period: ____________ **Age at first Period:** ____________ **Age of Menopause:** ____________

Date of last Pap Smear: ____________ **Date of last Mammogram:** ____________

Date of last Bone Density Screening: ____________

What is your current birth control method? ____________

The Pill ________ IUD ________ Tubal ligation ________ Hysterectomy ________ Vasectomy ________

Other: (describe) ____________

Do you Smoke? Yes ◯ No ◯ If yes, how many cigarettes per day? ____________

Do you consume Alcohol? Yes ◯ No ◯ If yes, how many drinks? Per day ______ Per week ______

Do you currently or have you <u>ever</u> used any Street Drugs? Yes ◯ No ◯

Do you consume Caffeine? Yes ◯ No ◯ If yes, how many cups per day? ____________

Do you Exercise? Yes ◯ No ◯ If yes, how many times per week? ____________

Current Medications: ____________

____

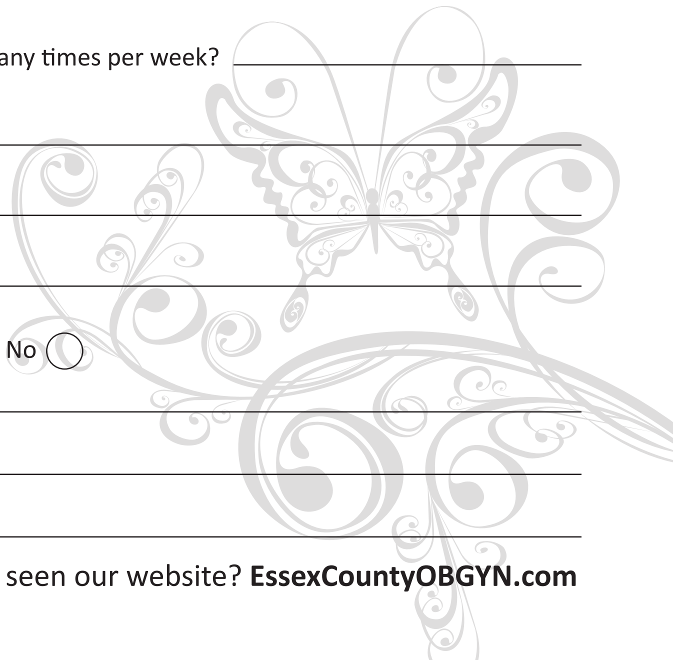
____

Do you have any Allergies? (Medications and Foods) Yes ◯ No ◯

If yes, please list them: ____________

____

Pharmacy Name/Location: ____________



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Have you seen our website? **EssexCountyOBGYN.com**

Name: ______________________ **Date of Birth:** ______________________

Have you ever had any of the following Gynecological/Obstetrical Surgeries? (Please check all that apply)

____ Caesarean Section ____ ERS ____ Ablation ____ LEEP
____ Essure ____ Pelviscopy ____ Ovarian Cystectomy ____ Abdominal Hysterectomy
____ Vaginal Hysterectomy ____ Laparoscopy ____ Tubal Ligation ____ Hysteroscopy
____ D & C ____ Removal of Ovaries: Right ◯ Left ◯ Both ◯
____ Other: ______________________

Have you ever had any of the following? (Please check all that apply)

____ Abnormal Pap Smears ____ HPV ____ Chlamydia ____ Herpes
____ HIV ____ Endometriosis ____ Pelvic Inflammatory Disease
____ Recurrent Miscarriage ____ Fibroid Uterus ____ Recurrent Ovarian Cyst ____ Chronic Pelvic Pain
____ Polycystic Ovarian Syndrome ____ Polycystic Ovarian Failure ____ Received HPV Vaccine
____ Diabetes ____ High Blood Pressure (Hypertension) ____ Heart Disease
____ Autoimmune Disease ____ Kidney Disease ____ Pulmonary Disease (Asthma) ____ Breast Disease
____ Thyroid Disease ____ Hyperthyroidism ____ Hypothyroidism ____ Psychiatric Illness
____ Hepatitis ____ Varicosities ____ Blood Transfusions ____ Depression
____ Other: ______________________

Have you ever had any of the following other surgeries? (Please check all that apply)

____ Appendectomy ____ Cholecystectomy (Removal of Gall Bladder)
____ Other Abdominal: ______________________
____ Breast Augmentation ____ Breast Biopsy ____ Breast Lumpectomy ____ Breast Mastectomy
____ Breast Reduction ____ Orthopedic:
____ Cardiac: ______________________ ____ Hernia
____ Other: ______________________

Are any of the following diseases in your family? If yes, then who? (Please check all that apply)

____ Breast Cancer: ______________ ____ Ovarian Cancer: ______________
____ Uterine Cancer: ______________ ____ Colon Cancer: ______________
____ Heart Disease: ______________ ____ Diabetes: ______________
____ Stroke: ______________ ____ Hypertension: ______________
____ Mental Health or Behavioral Health Issues: ______________________
____ Other: ______________________

Social History:

Marital Status: Single ◯ Married ◯ Divorced ◯ Widowed ◯

If you are single, are you currently involved in a relationship? Yes ◯ No ◯ ◯Male ◯Female ◯Both

Do you have children? Yes ◯ No ◯

Are you employed? Yes ◯ No ◯ Retired ◯ Student ◯ Stay-at-home mother ◯

Thank you.