Oakwood Seton Williamson *a care center of Central Texas OB/GYN Associates* **Patient History (Gyn)**

Date _____Name _____ Birth Date _____ Age _____ Race/Ethnicity _____

Phone: Home_____ Work_____ Cell _____ Email _____

Preferred Pharmacy: Name_ _____Pharmacy Address _____Phone _____

Is there someone we can thank for referring you?_____ Primary Care Physician _____

Circle your OWC Seton Williamson Physician: Thai Chao Teng

REASON FOR YOUR VISIT (give details as needed) _____

_____

******Although some of the information requested below may not seem pertinent, it helps us provide you with the best care. We ask that you fill out ALL of the following questions completely.******

PAST MEDICAL HX

Date of last **Annual Exam**_____ Date/Type of last **Labwork**:_____ Date of Last **Pap Smear** _____
Have you had an **abnormal pap smear**? _____ List dates & treatment _____
Date/ Results of last **Mammogram** _____
Date/ Results of last **Colonoscopy / flexsigmoidoscopy** _____
Date/ Results of last **Bone Density scan**? _____

Have you ever had a **Blood Transfusion**? (List date/reason) _____
Would you **accept blood or blood products** in case of an emergency? _____ If not, please explain_____
Did your mother receive a drug called **DES** when she was pregnant with you?_____
Do you have an **advanced directive**? _____

REPRODUCTIVE HISTORY

Age at 1st period _____ How far apart are your cycles (ex.28days) _____ How many days do you bleed (i.e. 5days)_____

***Flow**: □ light □ medium □ heavy □ clots **Symptoms**: □ cramps □ pelvic pain □ headaches □ mood changes

Date your **last period** started _____ How certain are you: □ Very □ Somewhat □ Not at all

Current Birth Control Method (i.e. condoms, birth control pills/ring/patch, IUD, menopause, Hysterectomy) _____

Do you desire a change? _____

Are you Menopausal: □ N/A □ Yes □ No Age at Menopause: _____ Are you on hormones? Type? _____

Total # of pregnancies:_____ # of Term Deliveries (***after*** 36weeks)_____ # of Preterm Deliveries (***before*** 36weeks)_____
How many Cesarean Sections _____ How many Living Children _____

Abortions (please list approximate year)_____

Miscarriages (please list approximate dates & weeks of pregnancy) _____

Ectopics (list dates, weeks of pregnancy, treatment): _____

Pregnancy or Delivery Complications: _____
_____
_____

SURGICAL HX

Please list any surgeries or hospitalizations you have undergone (D&C, Hysterectomy, Cesarean Section)

Year of Surgery	Type / Reason for	MD	Hospital

Meds / Allergy

List **Drug Allergies** (and the Reaction you had):

_____
_____
_____
_____
_____
_____
_____

List **Medications** (include over-the-counter & supplements), **Doses**, the **Reason** you are taking, and **Who prescribed** it:

_____
_____
_____
_____
_____
_____

PATIENT PAST MEDICAL HX & FAMILY HX

PERSONAL & FAMILY HISTORY (PLACE AN "X" IN THE *WHITE BOXES* THAT APPLY)

	You	Mother	Father	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Brothers or Sisters	Children	OTHER family members
Anemia										
Ashkenazi Jewish descent (Eastern European or Russian)										
Arthritis										
Asthma										
Birth defects (i.e. cleft palate, spina bifida…)										
Clotting disorder, or deep vein thrombosis										
Blood disorders (i.e. ITP, sickle cell)										
Breast disorders										
Cancer, Breast										
Cancer, Colon										
Cancer, Ovarian										
Cancer, Uterine/Endometrial										
Colon polyps										
Diabetes										
Endometriosis										
Epilepsy										
Gallbladder disease										
Genetic disorders (i.e. mental retardation, cystic fibrosis…)										
Glaucoma										
Heart disease or Mitral valve prolapse										
High blood pressure										
High cholesterol										
Kidney disorder/disease										
Mental Illness, type?										
Menstrual irregularities										
Osteoporosis										
Pelvic Inflammatory dis.										
Stroke										
Thyroid disorder										
Uterine anomalies										
…Still Living?	**X**									
…Deceased at Age?	**----**									

OTHER DISEASES/ILLNESSES:

SOCIAL HISTORY

Marital Status (please check one):
_____Single/Not Dating _____Married
_____Singe/ Dating _____Divorced
_____In a committed relationship _____Widowed
_____Engaged

Safety: Do you feel safe in your current relationship: Yes No
If not please explain_____

Have you ever been physically abused in a relationship: Yes No
If so, please explain _____

Have you ever had an unwanted sexual encounter: Yes No
If so, please let us know when this occurred: _____
_____

Substance Use:
Do you drink alcohol: Yes No
How many drinks per day or week: _____
Do you currently use any illicit drugs: Yes No
Type _____
How often _____
Tobacco use: current smoker former smoker have never smoked
If current use, how many cigarettes per day: _____
When did you start/stop smoking: _____

Occupation: _____

Do you Exercise: Yes No
Type _____
How often _____

Infection Risk:
Have you ever been sexually active? Yes No
Are you currently sexually active? Yes No
Sexual preference (circle one): Heterosexual Lesbian Bisexual Other
How many sexual partners in the last 1 year? _____
In your lifetime: 1-5__ 5-10__ 10-20__ 20+___

Have you ever had a sexually transmitted disease (STD)?: Yes No
Hepatitis (Type?) _____
Syphillis (when? treated?) _____
Chlamydia (when? treated?) _____
Gonorrhea (when? treated?) _____
Genital Herpes (taking meds?) _____
HPV (human papilloma virus) _____
Genital warts? _____

Have you ever had MRSA (Methicillin-resistant Staphylococcus aureus)?
Yes No

PRINT NAME HERE: _____

6/11/2014

The American College of Obstetrics and Gynecology (ACOG) recommends:

- HIV screening for all women ages 19-64
- HIV screening for sexually active teenagers under the age of 19
- HIV screening for women older than 64 who have had multiple partners in recent years
- Annual Chlamydia screening of all sexually active women age 25 and younger
- HPV (human papilloma virus) screening, in addition to an annual pap smear, for women over the age of 30

I would like to be screened for the following sexually transmitted diseases today: (please circle below)

Please be advised, we cannot guarantee insurance coverage for any tests

HPV Chlamydia Gonorrhea Genital herpes HIV Hepatitis B Syphilis *No testing today*

REVIEW OF SYMPTOMS

Constitutional:	**Circle One**:		
Frequent Fatigue	Current	Past	N/A
Excess weight gain	Current	Past	N/A
Excess weight loss	Current	Past	N/A
Eyes, Ears, Nose, Mouth:	**Circle One:**		
Frequent or severe headaches	Current	Past	N/A
Frequent lightheadedness	Current	Past	N/A
Breasts:	**Circle One**:		
Lumps	Current	Past	N/A
Pain	Current	Past	N/A
Swelling	Current	Past	N/A
Nipple discharge	Current	Past	N/A
Cardiovascular:	**Circle One:**		
Chest pain	Current	Past	N/A
Fainting	Current	Past	N/A
Swollen/Painful varicose veins	Current	Past	N/A
Calf pain	Current	Past	N/A
Respiratory:	**Circle One**:		
Frequent shortness of breath	Current	Past	N/A
Frequent Hoarseness	Current	Past	N/A
Gastrointestinal:	**Circle One**:		
Nausea/ Vomiting	Current	Past	N/A
Frequent Diarrhea	Current	Past	N/A
Frequent Constipation	Current	Past	N/A
Frequent Heartburn/ reflux	Current	Past	N/A
Abdominal Pain	Current	Past	N/A
Blood in stool	Current	Past	N/A
Hemorrhoids	Current	Past	N/A
Genitourinary:	**Circle One:**		
Urgency	Current	Past	N/A
Frequency	Current	Past	N/A
Pain with urination	Current	Past	N/A
Blood in urine	Current	Past	N/A
Frequent Urine leakage	Current	Past	N/A
Pain with intercourse	Current	Past	N/A
Genital sores	Current	Past	N/A

Genitourinary (continued)	**Circle One:**		
Irregular periods	Current	Past	N/A
Painful periods	Current	Past	N/A
Heavy periods	Current	Past	N/A
No periods	Current	Past	N/A
Possible pregnancy?	Current	Past	N/A
Abnormal vaginal discharge	Current	Past	N/A
Significant PMS	Current	Past	N/A
Integument (skin):	**Circle One:**		
New skin lesions	Current	Past	N/A
Changes to moles/skin lesions	Current	Past	N/A
Musculoskeletal:	**Circle One:**		
Joint pain	Current	Past	N/A
Joint swelling	Current	Past	N/A
Recent back pain	Current	Past	N/A
Endocrine:	**Circle One**:		
Excess bodily hair growth	Current	Past	N/A
Excess hair loss	Current	Past	N/A
Cold intolerance	Current	Past	N/A
Heat intolerance	Current	Past	N/A
Acne	Current	Past	N/A
Thyroid abnormalities/ treatment?	Current	Past	N/A
Psychiatric:	**Circle One:**		
Frequent Anxiety	Current	Past	N/A
Frequent Depression	Current	Past	N/A
Suicidal thoughts	Current	Past	N/A
Psychiatric treatment	Current	Past	N/A
Hematologic/Lymphatic:	**Circle One:**		
Easy bleeding	Current	Past	N/A
Easy bruising	Current	Past	N/A

List any other symptoms bothering you today: _____

_____

_____

YOUR HEIGHT: _____ **YOUR WEIGHT**: _____

PRINT NAME HERE: _____

PATIENT SIGNATURE: _____ **DATE COMPLETED:** _____