Oakwood Women's Centre-SW ***a care center of Central Texas OB/GYN Associates*** **Return Questionnaire**

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

1) DATE _____ NAME _____ DOB _____ AGE _____

2) Preferred PHARMACY NAME: _____PHARMACY ADDRESS: _____

3) Changes in Marital Status since your last visit? _____

4) Physician: Beth Thai Rebecca Teng Brenda Chao

5) REASON FOR VISIT (please explain your symptoms and how long they have been occurring) _____

_____

6) Please list current MEDICATIONS: _____Do you smoke cigarettes? Yes No

7) Please list any significant ALLERGIES (i.e. LATEX, eggs, shellfish, etc.) _____

8) When was the FIRST day of your LAST MENSTRUAL PERIOD? (If applicable) _____

How many days do you have bleeding? (i.e. 4 days) _____ How OFTEN do your periods occur? (i.e. every 28days)_____

9) What is your CURRENT BIRTH CONTROL METHOD? (Please choose one):

Nothing. . . . withdrawal. . . .condoms. . . .pills/ring/patch. . . . IUD. . . . tubal. . . .vasectomy. . . .menopause. . . .hysterectomy. . . .OTHER_____

If applicable, please list brand name of birth control pills/ring/patch/IUD:_____
If you have any concerns about this birth control method, please explain: _____

10) 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) **Note: We cannot guarantee insurance coverage for any tests**
HPV Chlamydia Gonorrhea Genital herpes HIV Syphilis Hepatitis B *No testing today*

11) Please list any CHANGES to your Medical/Surgical/Family history since you were last seen in our offices: _____

_____

12) Please circle any of the symptoms below that you are having TODAY:

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
Tenderness/ 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
Dizziness/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/ frequency	Current Past N/A
Pain with urination	Current Past N/A
Blood in urine	Current Past N/A

Genitourinary (continued)	**Circle One:**
Frequent Urine leakage	Current Past N/A
Pain with intercourse	Current Past N/A
Genital sores	Current Past N/A
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 skin lesions or moles	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
Past/Current psychiatric treatment	Current Past N/A
Hematologic/Lymphatic:	**Circle One:**
Easy bleeding	Current Past N/A
Easy bruising	Current Past N/A

Patient Signature _____ **Date:** _____

FOR STAFF ONLY BELOW THIS POINT: ** DO NOT SCAN THIS SIDE ** ** DO NOT SCAN THIS SIDE

Account # _____

Weight _____ Height _____ BP _____ Temp _____ UPT: Positive Negative

C.10 Results: Glucose_____ Bili _____ Ketones _____ Sp.Gravity _____Blood _____ pH _____ Protein _____

Urobili _____ Nitrite _____ Leuk _____

Pt desires: STD Testing……Lipids……Other_____

LABS ORDERED: _____

DIAGNOSIS CODES: _____

PROCEDURE CODES: _____