EAGLE OB/GYN

Date: _____

Name: **Date of Last Period:**

Reason for Visit:

PREFERRED PHARMACY:

PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR CURRENT HEALTH.

GENERAL	NO	YES
Weight Changes		
Fatigue		
Fever		
Chills		
Sweats/Night Sweats		
Recent Travel outside US		

EYES	NO	YES
Change In Vision		
Blurring		
Double Vision		

EARS, NOSE, THROAT	NO	YES
Vertigo/Dizziness		
Nosebleeds		
Sore Throat		
Tooth Ache		

ALLERGIES	NO	YES
Hives		

CARDIOVASCULAR	NO	YES
Chest Pain		
High Blood Pressure		
Irregular Heart Beat		
Palpitations		
Swelling in legs		

RESPIRATORY	NO	YES
Wheezing		
Cough		
Shortness Of Breath		

GASTROINTESTINAL	NO	YES
Appetite Changes		
Nausea		
Difficulty Swallowing		
Abdominal Pain		
Bloating		
Change in Bowel Habit		
Constipation		
Diarrhea/ Incontinence		
Blood in Stool		

MUSCULOSKELETAL	NO	YES
Muscle Aches		

URINARY	NO	YES
Painful Urination		
Urinary Urgency		
Frequent Urination		
Incontinence		
Difficulty Urinating		
Blood In Urine		

NEUROLOGICAL	NO	YES
Weakness		
Numbness		
Tingling		
Headaches		

PSYCHOLOGICAL	NO	YES
Depression		
Anxiety		
Trouble Sleeping		
Suicidal Thoughts		
Nervousness		

ENDOCRINE	NO	YES
Excessive Thirst		
Excessive Urination		
Heat/Cold Intolerance		
Loss Of Hair		

Blood/Lymph	NO	YES
Easy Bruising		
Abnormal Bleeding		
Swollen Glands		

Breast/Pelvic	NO	YES
Breast Pain		
Nipple discharge		
Pain with Intercourse		
Vaginal Itch		
Vaginal Discharge		
Abnormal Vaginal Bleeding		
Pelvic Pain		
Vulvar pain		
Vulvar rash		

SKIN	NO	YES
Rashes		
Sores		
New/Changing Mole		

Please continue to back of paper

Surgical History:

Type of Surgery	Date

Hospitalizations:

Reason	Date

Chronic Medical Conditions:

Menstrual History:

Last Period Start Date:
When was your first period:
Number Tampons/pads on heaviest day:
How many heavy days:
Length of period:
Current Method Birth Control:
How long used:

Sexual History:

Are you planning a pregnancy next year? Yes or No
Sexual Preference: Male/ Female / Both (circle one)
History of any of the following: (circle if YES)
Chlamydia Gonorrhea Syphllis Herpes Trich HPV HIV PID
Number of sexual partners past year: _____

OB History: Have you ever been pregnant? Y/N (circle one)

Date	Complications	Weeks completed	Miscarriage/ Abortion	Baby Weight	Vaginal	C-Sect

Medications:

Name	Dosage	Frequency	Problem

Allergies:

Family History: (circle all that apply below)

Chronic: Diabetes Heart Disease Stroke Blood Clotting Dx

Cancers: Breast Colon Ovarian Uterine Other

Health Maintenance:

Last Pap _____ Abnormals Y/N

Last Mammo _____ Abnormals Y/N

Last Colonoscopy _____

Last Bone Density Scan _____

Social History

Tobacco Use: Yes or No Type: _____ How much: _____ How long: _____

Alcohol Use: Yes or No Type: _____ How much: _____ How long: _____

Recreational Drugs: Yes or No Type: _____ How much: _____ How long: _____

Marital Status: Single Married Divorced Widowed Separated Abuse Y/N