University Medical Center

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Supersedes all prior versions

Chart# _____

UNIVERSITY MEDICAL CENTER OBSTETRICS AND GYNECOLOGY

Full Name _____DOB _____/_____/_____ Age _____

Today's Date_____ Are you allergic to latex? *(circle one)* *YES / NO*

Please CIRCLE the reason(s) why you are here today:

Routine checkup	Irritation	Abnormal bleeding	Pregnancy	Need contraception	Menopause
Need pap smear	Bad cramps	Leaking urine	Infertility	Sore Breasts	Abdominal pain
Discharge	Pelvic pain	PMS	Bloating, swelling		

Other (briefly explain)_____

Please CIRCLE the birth control method that applies to you:

Pills IUD Diaphragm Condoms Vasectomy Depo Provera Tubal Other_____

Date your last menstrual period started_____ **How many days did it last?** _____ **Age at 1st period** _____

Number of pregnancies_____ **Number of children**_____ **Number of miscarriages**_____ **Age at 1st delivery** _____

Have you ever had an abnormal pap smear? *(circle one)* *YES / NO* **If so, please indicate when**_____

Please CIRCLE any of the following medical problems that you have NOW or have HAD in the past:

Heart Asthma Clots in leg Liver Hepatitis High blood pressure Lung Diabetes
Thyroid Ulcers Kidney Gallbladder Seizures Other _____

Please CIRCLE any of the following surgeries/operations you have ever had and write the year that it was done:

D&C_____ Ovaries_____ Gallbladder_____ C-section_____ Tubes tied_____ Breast_____

Hysterectomy_____ Freeze, Laser, a Cone or Cervix or LEEP_____ Heart catheterization_____

Laparoscopy_____ Tonsils_____ Colonoscopy_____ Hysteroscopy_____ Appendix_____

List any other surgeries/operations that you have had and the year that it was done_____

_____

Have you been hospitalized in the last year? _____ **If so, Why?** _____

List current medications you take and dosage_____

_____

List any medications that you are ALLERGIC to and reaction you had_____

_____

_____

Have you ever had a BLOOD TRANFUSION? _____ **If so, what year?** _____

Do you smoke? *(circle one)* *YES / NO* If **so, how many packs per day?** _____ **Do you drink alcohol?** _____
Do you use drugs? _____ **Do you drink caffine?** _____

List relationship of BLOOD RELATIVES who have had the following:

Diabetes_____	Stroke_____	Cancer_____	High blood pressure_____
Heart Attack_____	Clots in legs_____	Breast Cancer_____	Other_____

If you were REFERRED here by another Doctor, please write his/her name_____
If you were REFERRED by another patient, please write their name & relationship to you_____
What is the name of your GENERAL FAMILY DOCTOR

By signing, I verify the information was provided by me and accurate

X_____ **Relationship to Patient** _____