WEST END OB/GYN, PC

PATIENT ENCOUNTER **TODAYS DATE:____________**

Welcome to our office. Please take a few minutes to provide us with information to better serve you.

Name ____ Email ___________________________________

DOB:________________ Sex:______________ Race:________ Hispanic___ Non-Hispanic___

Pharmacy Name:________________________________Pharmacy#:_____________________

Primary Care Physician (PCP)__________________________________Office#_______________________

What is the nature of your visit?☐ Annual exam☐ Consultation ☐ Pregnancy: Last Period:_______________

☐ Problem Visit (please explain) ____

How did you learn about this office? ____

Please check any medical problems that a doctor is treating.

	Condition	Year Diagnosed	Doctor Treating		Condition	Year Diagnosed	Doctor Treating
	Hypertension				Asthma		
	High Cholesterol				Seasonal Allergies		
	Diabetes				Other:		
	Thyroid						
	Depression						
	Anxiety						
	Osteoporosis						
	Osteopenia						

Please list any previous surgery(ies). (Example: tubal ligation, appendectomy, hysterectomy, colposcopy)

Surgery	Year	Doctor	Surgery	Year	Doctor

Please list current medications including dosing.

Medication	Dosage	Medication	Dosage

Have you had the flu vaccine this year? Yes or No If so, Date:____________Where?________________

Have you had the COVID vaccine? Yes or No

Date(s):____

Please list any allergies to medications. **Please list all other allergies. (Example: latex, food)**

MEDICATION	REACTION		ALLERGY	REACTION

Please tell us about any previous pregnancies. ☐ **Does not apply, I have never been pregnant before.**

	Total # of times pregnant		# of Vaginal Deliveries
	# of Miscarriages		# of C-Sections
	# of Abortions		# of Living Children

Have you ever had any **previous GYN problems?** (Please check box for those that apply)

	Abnormal Pap? Date______________________		STD: Date_______
	Abnormal Mammogram? Date:______________		Problems with Menstrual Cycle Date this Began__________________:
	History of Cold Sores/Fever Blisters: Date____________		Do you use Birth Control ☐ Yes ☐ **No** If yes, what form: ____________________

Please check the box below if you have **previously received the Human Papilloma Virus (HPV) injection, also called Gardasil, at another medical facility.**

☐ I have received the HPV vaccination. It was given to me at ____________________________________.
(name of facility)

I received a total of (please check box) ☐ 1, ☐ 2, ☐ 3 HPV injections

Family History: (check all that applies) **Family History Unknown** ☐ (check if this applies to you)

	Hyper-tension	Diabetes	High Cholesterol	Thyroid	Heart Disease	Breast Cancer	Colon Cancer	Uterine Cancer	Ovarian Cancer	Cervical Cancer
Mother										
Father										
Brother										
Sister										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										
Aunt										
Uncle										

AGE 40 & OVER	
Date of Last Mammogram	
Date of Last Colonoscopy	
Date of Last Bone Density	

Please answer the following questions: (if you are using IUD, Nexplanon or Depo Provera, answer these questions according to how your cycle was prior to the use of these:

At what age did your menstrual cycle / period start:_______________

How many days did your cycle last:_________________________

How many days between cycles; (for example 28 days)______________________

Social History: (check history that applies)

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Domestic Partner ☐ Other_________

Are you employed? ☐ Yes ☐ No What occupation? _________________________________

Do you use alcohol? ☐ Yes ☐ No If so, how often? ______________________

Illegal drug use, past or present? ☐ Yes ☐ No

Do you wear a seat belt? ☐ Yes ☐ No Do you exercise regularly? ☐ Yes ☐ No How Often: _________________

Have you ever experienced domestic abuse (Physical)? ☐ Yes ☐ No (Emotional) ☐ Yes ☐ No

Tobacco Use: ☐ Former User ☐ Current User Form of Tobacco: ______________________

If so, Age Started ________How Much Daily?___________________Date of Last Use of Tobacco:_______________

If you do use Tobacco would you like information on how to quit? ☐ Yes ☐ No

Gender Identity & LGTQ Identity:

Please choose one of the following:

- ☐ Identifies as Female
- ☐ Identifies as Male
- ☐ Transgender Male: Female to Male (FTM)
- ☐ Transgender Female: Male to Female (MTF)
- ☐ Gender non-conforming (neither exclusively male or female)
- ☐ Additional gender category / other : please specify ______________
- ☐ Choose not to disclose

Sexual Orientation:

- ☐ Heterosexual
- ☐ Bisexual
- ☐ Lesbian, gay, homosexual
- ☐ Something else, please specify: _________________________
- ☐ Don’t know
- ☐ Choose not to disclose

Sexually Active: Yes or No (circle one)