SAINT LOUIS ASSOCIATES IN OB/GYN INC.

Name_______________________________ Date of birth_______________ Today's date_______________

Referred by_______________________________

Well Woman Update: (please provide dates where applicable)

Last bone density ______________________(year)

Last colonoscopy ______________________(year)

Last mammogram______________________(year)

Last Pap smear ______________________(year)

HPV / Gardasil Vaccine series? _____YES_____NO

Hepatitis B series? _____YES_____NO

Any abnormal Pap smears? _____YES_____NO

Cervical Dysplasia (precancerous cells of the cervix)? _____YES_____NO

If yes, any treatment? Dates:

LEEP ______________________

Laser ______________________

Cryo (freezing) ______________________

Cone biopsy ______________________

Medical Hostory: (Do you now have or have you ever had)

- ☐ Asthma
- ☐ Autoimmune disorder ___________________
- ☐ Bleeding disorder
- ☐ Bone/Joint disease
- ☐ Cancer (type?) ___________________
- ☐ Chicken pox
- ☐ Chicken pox vaccine
- ☐ Chlamydia
- ☐ Deep Vein Thrombosis
- ☐ Depression/Anxiety
- ☐ Diabetes (type?) __I__II__Gestational
- ☐ Elevated cholesterol
- ☐ Fibrocystic breast
- ☐ Fibroids (type?) ___________________
- ☐ GERD / Reflux
- ☐ G.I. illness ___________________
- ☐ Gonorrhea
- ☐ Heart disease
- ☐ Hepatitis (type?) __A__B__C
- ☐ Herpes
- ☐ Infertility
- ☐ Irritable bowel syndrome
- ☐ HIV
- ☐ HPV / genital warts
- ☐ High blood pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Migraines
- ☐ Osteopenia
- ☐ Osteoperosis
- ☐ Ovarian cysts
- ☐ Pelvic inflam. disease
- ☐ Recurrent urinary tract infections
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Syphilis
- ☐ Trichomoniasis
- ☐ Tuberculosis

Surgical History:

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Medicines &Allergies:

Current medications & dosages______________________

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Vitamins / herbal supplements______________________

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Drug allergies______________________

Latex Allergy ____YES____NO

Family History: (include age of onset and type of cancer)

ILLNESS	Mother	Father	Brother	Sister	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Other Relative
Cancer(type)									
Diabetes(type)									
DVT									
Heart Disease									
Osteoporosis									

PLEASE COMPLETE BOTH SIDES

GYN History:

Age of first period?____________ If menopausal, age of menopause?____________

How often do you get your menstrual cycle? Every________ days, lasting ________ days.

Are your cycles? □ Regular □ Irregular □ Painful

Are you sexually active? □ Never □ Not currently □ Yes

Method of contraception:

□ None □ Vasectomy □ Rhythm Method □ Implanon
□ Pills □ Condoms □ NuvaRing □ IUD (type)___________
□ Essure □ Patch □ Depo Provera □ Tubal Ligation □ Other

Obstetrical History: (Please list all pregnancies, including miscarriages, abortions, and ectopic pregnancies)

Type: Vaginal, C-Section, forceps, or vacuum
Complications: Examples: preterm labor, diabetes, bleeding, high blood pressure, postpartum depression, etc
Anesthesia: epidural, local, general, or spinal

Date	Weeks	Length of Labor	Baby's Weight	Sex	Type of Delivery	Anesthesia	Complications
EXAMPLE	40	12hrs	7lb 8oz	F	Vaginal	Epidural	HBP. Gest diabetes

Social History:

Occupation:____

Are you? □ Single □ Married □ Engaged □ Significant Other □ Divorced □ Widowed

Significant other's name:___________________________________Phone:____________________________________

Other emergency contact name:_______________________________Phone:____________________________________

Tobacco use: □ Never □ Current_____# of cigarettes/day □ Former, quit at age_____

Alcohol use? _____YES _____NO *if yes, the average number of drinks/week_________________________

Street drugs? _____YES _____NO *if yes, the type used and last use_________________________________

How many times per week do you exercise? _____1x _____2x _____3x _____4x _____5x _____6+

Per session: _____20 min _____30 min_____45 min _____60+ min

Any history of violence or abuse in your current household or in your past _____YES _____NO

Do you have any cultural or religious considerations that need special attention _____YES _____NO

Signature____ Date_______________________________

Subsequent year update (please sign after reviewing and making necessary changes)

Year 2 review ____ Date______________________________

Year 3 review ____ Date______________________________

Year 4 review ____ Date______________________________

PLEASE COMPLETE BOTH SIDES