GRAND LAKE OB/GYN℠
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM

Patient Label

****Please fill out form (front and back) and bring to your appointment.****

What brings you to the office today? _____

Pregnancies:

Number of pregnancies: _____
Number of live births: _____
Number of preterm (born before 37 weeks) deliveries: _____
Spontaneous Abortions (miscarriages): _____
Number of living children: _____
Elective Abortions: _____
Vaginal Births: _____
C-Sections: _____
Biggest baby's weight: _____

Allergies: (Any known allergies to medication or foods and what reaction you have.)

_____
_____
_____

Pharmacy Preference: _____

Medications: Please list any new meds!! Attached is copy of our current list for you, if you are a new patient please list all your medications including name, dose, how often you take it and when you took your last dose. *** (*Example: Lisinopril, 10mg once a day, last taken this morning 8am*) ***

Drug	Dosage	Time(s) per day	Last taken & time

Do you perform your own self breast exams monthly: ☐ YES ☐ NO

Review of Systems: CHECK ALL THAT APPLY!

X	General	X	Skin	X	Breast
	Chills		New lesion		Breast lump
	Fever		Rash		Nipple discharge
	Fatigue/feeling tired		Skin color change		Nipple retraction
	Feeling Well		itching		Tenderness
	Unwanted weight loss				Swollen glands
	Loss of appetite				Swelling
					Nipple pain
					Recent breast size change
X	**Neck**	X	**Respiratory**	X	**Cardiovascular**
	Swollen glands		Cough		Chest pain
	Neck pain		Coughing up blood		Pain in calves when walking
	Stiffness		Difficulty breathing with activity		Lower extremity swelling
			Difficulty breathing at rest		Shortness of breath while lying flat
			Wheezing		Feeling faint at times
					Irregular heart beat
X	**Gastrointestinal**	X	**Genitourinary**	X	**Female Gynecological**
	Abdominal pain		Urinary burning		Vaginal discharge
	Blood in stools		Urinary bleeding		Vaginal itching
	Constipation		Urinary frequency		Heavy periods
	Diarrhea		Urinary hesitancy		Irregular periods
	Nausea		Urinary incontinence		Painful periods
	Vomiting		Change in bladder habits		No periods
	Black tarry stool		Urinary urgency		Pelvic pain
	Change in bowel habits		Nighttime urination		Vaginal burning
	Difficulty in swallowing				Vaginal dryness
	Heartburn				Menopausal symptoms/hot flashes
	Rectal pain				Sexual dysfunction
	Stool incontinence				Painful sex
					Low sex drive
X	**Neurological**	X	**Psychiatric**	X	**Musculoskeletal**
	Confusion		Anxiety		Back pain
	Dizziness		Depression		Joint swelling
	Headache		Hallucinations		Joint redness
	Weakness		Insomnia		Muscle pain
	Change in level of consciousness		Mood problems		Joint stiffness
	Change in speech		Suicidal ideation		Muscle weakness
	Difficulty with walking		Delusions		Joint pain
	Tingling				
	Loss of balance				
	Seizures				
	Memory loss				
	Numbness				
X	**Heme/Lymph**	X	**Endocrine**	X	
	Enlarged lymph nodes		Cold intolerance		
	Night sweats		Heat intolerance		
	Abnormal bleeding		Excessive thirst		
	Abnormal bruising		Excessive urination		
	Tender lymph nodes		Appetite changes		

Contraception History:

Are you currently sexually active? ☐ YES ☐ NO
How are you preventing pregnancy? _____
Are you interested in information on types of birth control? ☐ YES ☐ NO
Have you been exposed to any sexually transmitted infections? ☐ YES ☐ NO
If yes, please check:

☐ Chlamydia ☐ Gonorrhea ☐ HPV ☐ Syphilis ☐ Genital Herpes ☐ HIV

YOUR Medical Issues/Diagnosis: (any known medical problems)

_____
_____
_____
_____

YOUR Surgeries: (please indicate what and when)

_____
_____
_____
_____

Family History: Please list if it is Maternal (mother's side) or Paternal (father's side) and which family member.
*** *Example: Grandma (Paternal)* ***

Stroke:_____
Diabetes: _____
High Cholesterol: _____
Heart Disease: _____
Bleeding Disorder/Anemia: _____
Kidney Disease: _____
Cancer (and what kind of cancer): _____
Arthritis: _____
Hypertension: _____
Asthma: _____
Thyroid Disease: _____
Liver Disease: _____
Drug Abuse: _____
Tuberculosis: _____
Alcohol Abuse: _____
Seizure Disorder: _____
Additional: _____
_____
_____

Menstrual History: _____
_____

Last Menstrual Period (date): _____
Age Cycles Began: _____
Length of Cycles (start to start, number of days): _____
How many days does the bleeding last: _____
Color: ☐ Bright Red ☐ Dark Brown
Menstrual Cycles: ☐ Regular ☐ Irregular
Type of flow: ☐ Light ☐ Moderate ☐ Heavy
Clotting: ☐ Rarely ☐ Frequently ☐ Occasionally
Mid Cycle Bleeding: ☐ YES ☐ NO
Age at Menopause: _____
Postmenopausal Bleeding: ☐ YES ☐ NO

Social:

Marital Status/Spouse Name: _____
Your Occupation: _____
Who lives in your household? _____
Living arrangements (*ex. House, Apartment, Condo*) _____
Are you exercising? ☐ YES ☐ NO How often: _____
Have you traveled outside of the United States in the last 6 months? ☐ YES ☐ NO Where: _____
Do you have any pets in the home? _____
Smoker: ☐ YES ☐ NO How many years: _____ How many packs/day: _____
Previous Smoker: ☐ YES ☐ NO When did you quit: _____
Caffeine: ☐ YES ☐ NO How much per day/coffee, pop, tea: _____
Alcohol: ☐ YES ☐ NO How often: _____
Drugs: ☐ YES ☐ NO Type: _____

Do you have a living will? ☐ YES ☐ NO
Do you have a healthcare Power of Attorney? ☐ YES ☐ NO
Are you an Organ Donor? ☐ YES ☐ NO
Do you have a DNR or DNRCC ☐ YES ☐ NO

If yes to any of the above, are the documents on file at JTDMH? _____
_____
_____

Please list information for any other physicians you currently see: (*ex: Dr. Smith, Urologist, Celina, OH*)

_____
_____
_____
_____
_____
_____