advocare
The Modern Woman
OB/GYN

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Name:_____ Date of Birth:_____

Primary Care Provider: _____ Pharmacy: _____

Referred By: _____

REASON FOR VISIT:

_____

_____

MEDICATION:

List all **current** medications including dosage and frequency. Please also list any herbs, vitamins and supplements:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY: (Please select all that apply)

- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood Clots
- ❑ Cancer
- ❑ Cholesterol
- ❑ Diabetes
- ❑ Migraines with Aura
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Kidney Stones
- ❑ Liver Disease
- ❑ Osteopenia
- ❑ Osteoporosis
- ❑ Seizures
- ❑ Thyroid Imbalance
- ❑ Other: _____

ALLERGIES: (Please also list your allergic reactions)

_____ _____

_____ _____

_____ _____

GYNECOLOGICAL HISTORY:

- When was your last pap smear? _____ Was it normal? ⬜ Yes ⬜ No
- Have you ever had any of the following? (Please select all that apply)
  - ❑ Chlamydia
  - ❑ Fibroid Uterus
  - ❑ Genital Herpes
  - ❑ Gonorrhea
  - ❑ HIV
  - ❑ HPV
  - ❑ Ovarian Cyst
  - ❑ Uterine Polyp
  - ❑ Syphilis
  - ❑ Other: _____
- Are you currently sexually active? ⬜ Yes ⬜ No

  Method of contraception? ⬜ Condoms ⬜ Pills ⬜ IUD ⬜ Other _____
- Age of first intercourse? _____ How many sexual partners have you had? _____
- Have you received the HPV/Gardasil vaccination? ⬜ Yes, injections completed

  ⬜ No, none completed ⬜ 1 or 2 out of the 3 injections completed ⬜ What's Gardasil?

OBSTETRICAL HISTORY:

- How many times have you been pregnant? _____
- How many: Full term deliveries (>37 weeks)? ____ Preterm deliveries (24-36 weeks)? _____ Miscarriages? _____ Abortions? _____ Ectopic pregnancies? _____
- How many living children do you have? _____

Please fill out the following chart concerning all pregnancy history.

Date	Weeks of Gestation	Vaginal or c-section	Any complications?	Hospital	Doctor	Birth weight	Birth Sex

SURGICAL HISTORY: (Please include **dates** and any complications)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

MENSTRUAL HISTORY:

- How old were you at the onset of your first period? _____
- When was the first day of your last menstrual period? _____
- If menopausal, what age did you have menopause? _____
- Are your menses regular? ⬜ Yes ⬜ No
- Any bleeding between periods? ⬜ Yes ⬜ No
- How many days apart are your periods? _____
- How many days do you bleed for? _____
- The flow is: ⬜ light ⬜ medium ⬜ heavy
- Are the periods painful? ⬜ Yes ⬜ Mild, but relieved with medication ⬜ No

ROUTINE EXAMS (if applicable):

- When was your last mammogram? _____ Was it normal? ⬜ Yes ⬜ No ⬜ N/A
- When was your last colonoscopy? _____ Was it normal? ⬜ Yes ⬜ No ⬜ N/A
- When was your last DEXA scan (bone density test)? _____

  What was the result? _____

FAMILY HISTORY:

Does anyone in your family have a history of any of the following? (If yes, list family members and age of diagnosis.)

- Breast Cancer ⬜ No ⬜ Yes _____ Age at diagnosis: _____
- Colon Cancer ⬜ No ⬜ Yes _____ Age at diagnosis: _____
- Ovarian Cancer ⬜ No ⬜ Yes _____ Age at diagnosis: _____
- Uterine Cancer ⬜ No ⬜ Yes _____ Age at diagnosis: _____
- Does anyone in your family have a history of blood clots? ⬜ No ⬜ Yes _____

SOCIAL HISTORY:

- Are you: ⬜ Single ⬜ Married ⬜ Widowed ⬜ Divorced ⬜ Separated ⬜ Widowed
- Sexual preferences: ⬜ Men ⬜ Women ⬜ Both
- Do you have a history of domestic violence? ⬜ No ⬜ Yes

  Do you feel safe in your current living environment? ⬜ No ⬜ Yes
- Describe your alcohol intake: ⬜ Never ⬜ Socially ⬜ Frequently ⬜ Problematic
- Any tobacco use? ⬜ Never ⬜ Current, ____ # of cigarettes per day

  ⬜ Former, Quit at age: _____ Age Started: _____
- Any recreational drug use? ⬜ Never ⬜ Currently using _____ ⬜ Former _____
- Do you exercise? ⬜ Regularly ⬜ Sometimes ⬜ Rarely ⬜ No
- Describe your diet: ⬜ Balanced ⬜ Vegetarian ⬜ Needs improvement
- What is your occupation? _____