**Kitsap OBGYN, PLLC**

Name ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gynecology**: Do you have bleeding between periods? Y/N Do you have bleeding with intercourse? Y/N

Do you have pain with periods? Y/N Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_

Have you experienced sexual abuse or physical abuse? Y/N

Date of last pap \_\_\_\_\_ Was it normal? Y/N Any history of abnormal paps? Y/N

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_ What treatment did you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last mammogram \_\_\_\_\_\_\_\_\_ Was it normal? \_\_\_\_\_\_\_\_\_\_

Date of last colonoscopy \_\_\_\_\_\_\_\_\_\_ Was it normal? \_\_\_\_\_\_\_\_\_\_

**Obstetric History:** (Include all pregnancies)

Delivery Date Gestational Age Type of delivery Vaginal or C-Section Newborn Weight Complications

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Medical Problems: (check all that apply and explain)**

\_\_\_\_\_ Arthritis \_\_\_\_\_ Cholesterol elevated \_\_\_\_\_ Kidney or bladder problems

\_\_\_\_\_ Asthma \_\_\_\_\_ Clotting Problems \_\_\_\_\_ Seizures

\_\_\_\_\_ Bowel/stomach problems \_\_\_\_\_ Depression or other \_\_\_\_\_ Sleep Apnea CPAP? \_\_\_\_\_

\_\_\_\_\_ Cancer \_\_\_\_\_ Heart or vascular problems \_\_\_\_\_ Hypothyroid/Hyperthyroid

\_\_\_\_\_ Cataracts or glaucoma \_\_\_\_\_ High blood pressure \_\_\_\_\_ Diabetes

**List all Medications, supplements you are currently taking along with dose and frequency:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

Diabetes Yes\_\_ No\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hypertension Yes\_\_ No\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Premature heart attack (male <55y/o & female <65 y/o) Yes\_\_ No\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High cholesterol (on medication) Yes\_\_ No\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid problems Yes\_\_ No\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Osteoporosis Yes\_\_ No\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clotting Disorder Yes\_\_ No\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Cancer Yes\_\_ No\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colon Cancer Yes\_\_ No\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ovarian Cancer Yes\_\_ No\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Uterine Cancer Yes\_\_ No\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Cancer Yes\_\_ No\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgeries:**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:** Married\_\_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_\_ Single \_\_\_\_\_\_

Tobacco: Y/N Quit year\_\_\_\_\_\_ Alcohol? Y/N Drugs? Y/N Marijuana? Y/N Exercise? Y/N \_\_\_\_\_ #of days per week