ADVANCED
WOMEN'S HEALTH OF NASHVILLE
OBSTETRICS • GYNECOLOGY • INFERTILITY

Name_____DOB_____

WELCOME TO OUR PRACTICE

PATIENT MEDICAL INFORMATION

Date:_____ Age:_____ Primary Care Physician:_____

First Day of last Menstrual Period: _____

REASON FOR VISIT: _____

_____

_____

OBSTETRICAL HISTORY

YEAR	DELIVERY TYPE	WEIGHT	WEEKS	MALE OR FEMALE	NAME	COMPLICATIONS

GYNECOLOGIC HISTORY

Age of first period_____# of days between periods_____# of flow days _____

Last Pap_____Date & treatment for abnormal paps_____Have you had the HPV vaccine? _____

Date of last Colonoscopy_____ Date of last Bone Density _____

Do you do self-breast exams?_____Any family history of breast cancer? _____

Last mammogram_____Date & treatment of abnormal mammogram_____

Have you ever been sexually active?_____Are you sexually active now? _____Sexual orientation_____

Birth control method_____Any history of sexually transmitted infections? _____

Any history of abuse? (verbal, sexual, or physical) _____

Do you leak urine with coughing or sneezing?_____ at rest?_____with urge? _____

DRUG ALLERGIES_____

MEDICATIONS	STRENGTH	DOSAGE SCHEDULE

MEDICAL HISTORY (please include all previous diagnoses, whether big or small)

_____

_____

SURGICAL HISTORY (please include date of all previous surgeries, big and small)

_____

_____

(Please fill out front and back)

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Name_____DOB_____

SOCIAL HISTORY

Have you ever smoked?_____How much per day, now?_____How many years? _____

Do you currently or do you have a past history of illicit drug use? _____

Do you use alcohol?_____If so, how much do you drink daily or weekly? _____

Have you ever had a blood transfusion?_____If so, when? _____

Are you single or married? _____

REVIEW OF SYSTEMS (please circle if you are feeling any of the following symptoms today)
Constitutional: Feeling tired or poorly, fever, chills, recent weight loss, recent weight gain
Chest: Chest pain or discomfort, shortness of breath, palpitations, cough, difficulty breathing
GI: Abdominal pain, nausea, vomiting, diarrhea, constipation, heartburn, decreased appetite
Skin/musculoskeletal: Rash, joint pain, back pain
Heme/endocrine: Easy bruising, excessive sweating, night sweats, excessive thirst, temperature intolerance
Neuro: Headache, migraines, ringing in ears, sleep disturbances, depression, anxiety
Ear, Nose, Throat: Nasal congestion, nose bleeds, difficulty swallowing, sore throat, hoarseness
Urinary: Pain with urination, increased frequency of urination, blood in urine, leaking urine
Gynecologic: Abnormal vaginal discharge, itching, irritation, irregular bleeding, unexplained vaginal bleeding, heavy menstrual periods, painful menstrual cramps, pelvic pain, pain with intercourse, post-menopausal bleeding
OTHER: _____

_____

FAMILY HISTORY (Heart problems, prolonged bleeding, stroke, diabetes, high blood pressure, congenital birth defects, cancers, etc.…) _____

_____

THANK YOU SO MUCH FOR COMPLETING THIS FORM SO WE CAN TAKE BETTER CARE OF YOU!!!

Is there any additional information you would like to share? _____

_____

OFFICE USE BELOW PLEASE

Wt_____Ht_____ BMI_____BP_____P_____T_____R_____

Urinalysis_____UPT_____HPV indicated?_____Ordered? _____

ASSESSMENT/PLAN _____

_____

_____

_____

_____

_____

_____

Patient Signature_____ Date _____

THANK YOU FOR BEING PART OF OUR PRACTICE! HAVE A WONDERFUL DAY!