Ob/Gyn Associates of Columbus

CONFIDENTIAL
PLEASE FILL OUT COMPLETELY FRONT AND BACK

Annual History and Physical Examination

Name:____________________________ Acct #_______________ Date of exam:______________________

Date of birth:________________ Birth Control Method______________________ LMP:_______________

Medications (see sheet): Please list all prescription and non-prescription medication (with dosages) you take regularly, including vitamins, supplements, and herbs.

1.__________________________ 6.__________________________

2.__________________________ 7.__________________________

3.__________________________ 8.__________________________

4.__________________________ 9.__________________________

5.__________________________ 10.__________________________

Allergies: Please list any new allergies since your last exam.____

Surgeries: Please list any surgeries you have had since your last exam.____

____

Family History: Have there been any new illnesses in your family since your last exam in our office? Yes___________No_______If yes,

please list the family member and illness or cause of death.____

____

Do you have, or are you being treated for any of the following:

CONSTITUTIONAL

Poor appetite	**Y**	**N**
Unexplained weight loss	**Y**	**N**

HEAD AND NECK

Blurred or double vision	**Y**	**N**
Loss of vision	**Y**	**N**
Frequent or severe headaches	**Y**	**N**
Trouble swallowing	**Y**	**N**

RESPIRATORY

Shortness of breath	**Y**	**N**
Decreased exercise capacity	**Y**	**N**
Asthma	**Y**	**N**

CARDIOVASCULAR

Chest pain or pressure	**Y**	**N**
Irregular heart beat or palpitations	**Y**	**N**
Heart attack	**Y**	**N**
Heart murmur	**Y**	**N**
Rheumatic fever	**Y**	**N**

GASTROINTESTINAL

Heartburn or indigestion	**Y**	**N**
Abdominal pain	**Y**	**N**
Diarrhea or constipation	**Y**	**N**
Blood in stool	**Y**	**N**
Hepatitis	**Y**	**N**

GENITOURINARY

Pain or burning on urination	**Y**	**N**
Leakage of urine	**Y**	**N**
Kidney stones	**Y**	**N**

NEUROLOGICAL

Dizziness	**Y**	**N**
Weakness	**Y**	**N**
Fainting	**Y**	**N**
Seizures	**Y**	**N**
Strokes	**Y**	**N**

Endocrine

Diabetes	**Y**	**N**
Thyroid disease	**Y**	**N**
High blood pressure	**Y**	**N**
Loss in height	**Y**	**N**

HEMATLOLOGICAL

Anemia	**Y**	**N**
Bleeding disorder	**Y**	**N**

CANCER/ PSYCHIATRIC

Trouble sleeping	**Y**	**N**
Feel tired all the time	**Y**	**N**
Feel nervous, tense or stressed	**Y**	**N**
Feel depressed or “down in the dumps”	**Y**	**N**

Social History: Please circle response and fill in blanks.

Are you married, single, divorced or widowed? M (how long? ______________) S D W

Do you exercise? Y N If yes, what type? How often? ____

Do you wear a seat belt? Y N

Do you smoke? Y N If yes, how much daily? ______ packs per day. For how long? ___________ years.

Have you ever smoked? Y N If yes, when did you stop? _________________________________

Do you drink alcohol? Y N If yes, please answer the following questions.

What type of alcohol? ____________________________ How many drinks per week? ______________________

Do you ever feel the need to cut down on your drinking? Y N

Do you ever feel annoyed by criticisms about your drinking? Y N

Do you ever have guilt feelings about your drinking? Y N

Do you ever take a morning "eye opener" drink? Y N

Have you ever been in a relationship where you were hit or threatened? Y N

Have you used recreational drugs? (marijuana, cocaine, heroine, crack, meth, etc.) Y N
When _______ Last Used ________

Please list the time you last had the following tests done.

Tetanus shot _____________________________ Testing for HIV (AIDS virus) _____________________________

Pneumonia vaccine _____________________________ Pap smear and pelvic exam _____________________________

Flu shot _____________________________ Mammogram _____________________________

Sigmoidoscopy/colonoscopy ________________________

Ob/Gyn History (Please answer yes or no as appropriate.)

Onset on 1st period-age _____________________ Last period if menopausal __________________________________-

Menses: Monthly ____________ Irregular ____________ Days of flow ____________ Time between pad/tampon change ____________

Bleeding between periods ____________ After intercourse ____________ Pain with intercourse ____________

History of abnormal paps ____________ When ____________ Treatment done? ____________

Previous pregnancies ____________ Living children ____________ Miscarriages ____________ Abortions ____________

Do you do self breast exams? ____________ Current changes in breast (nipple discharge, lump, etc.) ____________

Have you had a sexually transmitted infection? (Gonorrhea, Chlamydia, Herpes, Syphyllis, HIV, HPV, or Genital Warts) ____________

Same partner for how long ____________ Is/are your partner(s) male, female or both ____________

Have you changed partners in the last 6 months? ____________

Age of 1st sexual experience ____________ Number of partners in life ____________

Are you sexually active? ____________ currently ____________