WOMEN LIVING WELL
OBSTETRICS & GYNECOLOGY

Today's Date: ____________ **Name:** __________________________________ **Date of Birth:** __________

INITAL REVIEW OF SYSTEMS

HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING SYMPTOMS IN THE **PAST MONTH**?

CIRCLE **YES** OR **NO**

GENERAL			GENITOURINARY		
Fatigue	Y	N	Burning with Urination	Y	N
Fever/Chills	Y	N	Urinary Frequency	Y	N
Night Sweats	Y	N	Urinary Incontinence	Y	N
Weight Gain	Y	N	Blood in Urine	Y	N
Weight Loss	Y	N	Menstrual Irregularity	Y	N
EYES			Painful Menstrual Cycle	Y	N
Vision Changes	Y	N	Painful Sex	Y	N
EAR, NOSE, & THROAT			Vaginal Discharge	Y	N
Hearing Loss	Y	N	Vaginal Dryness	Y	N
Runny Nose	Y	N	Vaginal Itching	Y	N
Ear Pain	Y	N	NEUROLOGIC		
Sinus Problem	Y	N	Headache	Y	N
Sore Throat	Y	N	Dizziness	Y	N
RESPIRATORY			Tingling or Numbness	Y	N
Cough	Y	N	Memory Difficulties	Y	N
Shortness of Breath	Y	N	MUSCULOSKELETAL		
Wheezing	Y	N	Back Pain	Y	N
CARDIOVASCULAR			Muscle Weakness	Y	N
Chest Pain	Y	N	Joint Pain	Y	N
Leg Swelling	Y	N	Joint Swelling	Y	N
Palpitations/Irregular Heartbeat	Y	N	ENDOCRINE		
GASTROINTESTINAL			Cold Intolerance	Y	N
Abdominal Pain	Y	N	Heat Intolerance	Y	N
Blood in Stools	Y	N	Excessive Thirst	Y	N
Constipation	Y	N	Excessive Amount of Urine	Y	N
Diarrhea	Y	N	PSYCHOLOGY		
Heartburn	Y	N	Difficulty Sleeping	Y	N
Loss of Appetite	Y	N	Anxiety	Y	N
Nausea	Y	N	Depression	Y	N
Vomiting	Y	N	Suicidal Thoughts	Y	N
BREAST			HEMATOLOGIC/LYMPHATIC		
Breast Lump	Y	N	Easy Bleeding	Y	N
Tenderness	Y	N	Easy Bruising	Y	N
Nipple Discharge	Y	N	Swollen Lymph Glands	Y	N
SKIN			ALLERY/IMMUNOLOGY		
Hair Loss	Y	N	Hives	Y	N
Rash	Y	N	Seasonal Allergies	Y	N
New Skin Lesions	Y	N	Environmental Allergies	Y	N

Lifeline Medical Associates

WOMEN LIVING WELL
OBSTETRICS & GYNECOLOGY

Medical History

Today's Date: ____________ **Name:** ______________________________ **Date of Birth:** ____________

What pronouns do you use: She/Her He/His They/Them

Please Circle all that apply to YOUR health (previous and current conditions):

Alcoholism	Arthritis	Asthma	Blood Clot/DVT/PE	Cancer
Chlamydia	Depression/Anxiety	DES Exposure	Diabetes	Drug Addiction
Eating Disorder	Genital Warts	Gonorrhea	Headaches/Migraines	Heart Disease
Hepatitis	Herpes	High Blood Pressure	High Cholesterol	HIV
Kidney Disease	Lupus	Osteoporosis	Seizures	Syphilis
Stroke	Thyroid Disease			

If you circled YES to any of the above, please explain and give date of onset:

____

____

____

GYN HISTORY			
Age when period started?		What is your normal cycle length (time between periods)	
How long is your period?		Flow rate	Light Medium Heavy
Start of Last Period		Do you have pain with periods?	Yes No

I am:	Heterosexual	Homosexual	Bisexual	Non-Binary
Are you having sex?	Yes		No	
Do you have sex with	Men	Women	All	Neither
Any new partners since last visit?	Yes		No	
At any time, has your partner ever hit you, kicked you, or otherwise hurt you?	Yes		No	
Are there concerns about your sexual activity which you may want to discuss with your provider?	Yes		No	

METHOD OF CONTRACEPTION		
None/Other	Condoms	Oral Contraceptive (pill)
IUD/Implant	Vasectomy	Tubal Ligation
Depo Provera	Rhythm/Natural Family Planning	Withdrawal

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OB HISTORY					
TOTAL # OF PREGNANCIES		TOTAL # OF MISCARRIAGES		TOTAL # OF ABORTIONS	

	DATE	GENDER	METHOD OF DELIVERY	EARLY LABOR?	COMPLICATIONS	LOCATION OF DELIVERY
1						
2						
3						
4						

SURGICAL HISTORY

Surgery Name & Date:

____

____

FAMILY HISTORY

Please note Family Member & Maternal (M) or Paternal (P):

High Blood Pressure:	________	Breast Cancer:	________
Diabetes:	________	Ovarian Cancer:	________
Heart Disease:	________	Uterine Cancer:	________
Thyroid Disease:	________	Colon Cancer:	________
Genetic Disorder:	________	Uterine Cancer:	________
Stroke/DVT:	________	Osteoporosis:	________
Bleeding Disorder:	________	Other:	________

Tobacco Use	Current		Previous		Never	
Alcohol Use (drinks/day)	0	1	2	3	4	5+
Drug Use	Yes			No		
Exercise	Type:			How often?		

CURRENT MEDICATIONS		
Medication	Dose	When Taken

ALLERGIES to medications, environment, or dyes:			
LAST DEXA:		LAST MAMMOGRAM	
LAST COLONOSCOPY		LAST PAP SMEAR	