PRATT HEALTHCARE

Pratt Healthcare OB/GYN

Name: _____ Age: _____ Today's Date: _____

Would you like a copy of today's visit sent to your PCP? ☐ Yes ☐ No
PCP Name (First & last): _____
Name and Location of pharmacy: _____ Mail Order Pharmacy: _____
Reason for visit: _____

GYNECOLOGICAL HISTORY

Marital Status: ☐ Single ☐ Married ☐Divorced ☐ Separated ☐ Widowed ☐ Other

First day of last period:	Are you sexually active?
Duration of flow:	Any new sexual partners since last exam?
Time between start of periods:	Do you use contraception?

HELPING US PREPARE FOR YOUR VISIT BY TELLING US MORE ABOUT YOUR HEALTH AND THE REASON YOU ARE HERE TODAY.

1. What are the 2-3 most important things you would like to discuss with your doctor today?

2. Please list anything we need to know about your health since the last visit.

3. Since your last visit, have you been hospitalized? If so, when and where?

4. Since your last visit, have you seen any other healthcare provider? PCP ____ Specialist ____
5. Have you had any bloodwork? _____ X-rays _____ Colonoscopy _____ If so, when and why?
6. Do you smoke or use tobacco?
___ No, and I never have
___ Not now, but I used to
___ Yes, some days
___ Yes, everyday ___packs/day

Do you drink alcohol?
___ No, and I never have
___ Not now, but I used to
___ Yes, some days
___ Yes, everyday

Do you use social drugs?
___ No, and I never have
___ Not now, but I used to
___ Yes, some days
___ Yes, everyday

REVIEW OF SYMPTOMS (Check all that apply)

CONSTITUTIONAL ☐ WEIGHT LOSS ☐ WEIGTH GAIN ☐ FATIGUE ☐ FEVER/CHILLS	*SKIN/BREAST* ☐ SKIN RASH ☐ NIPPLE DISCHARGE ☐ PAIN IN BREAST ☐ LUMPS IN BREAST	*CARDIOVASCULAR* ☐ PALPITATIONS (RAPID HEART BEAT) ☐ IRREGULAR HEART BEAT ☐ CHEST PAIN
GASTROINTESTINAL ☐ ABDOMINAL PAIN ☐ BLOATING ☐ BLOOD IN STOOL ☐ CONSTIPATION ☐ POOR APPETITE ☐ DIARRHEA ☐ NAUSEA	*PSYCHIATRIC* ☐ INSOMNIA ☐ DEPRESSION ☐ ANXIETY ☐ MOODINESS	*REPIRATORY* ☐ COUGH ☐ SHORTNESS OF BREATH ☐ PAIN WITH BREATHING
URINARY ☐ BURNING WITH URINATION ☐ URINARY FREQUENCY OR URGENCY ☐ URINARY INCONTINENCE ☐ BLOOD IN URINE	*LYMPHATIC* ☐ SWOLLEN LYMPH NODES ☐ LUMPS IN GROIN, UNDER ARM ☐ SWOLLEN LEGS	*ENDOCRINE* ☐ FATIGUE ☐ HAIR OR SKIN CHANGES ☐ HEAT OR COLD INTOLERANCE ☐ HOT FLASHES
GYNECOLOGICAL ☐ ABNORMAL BLEEDING ☐ VAGINAL DISCHARGE/IRRITATION ☐ SEVERE CRAMPING ☐ PELVIC PAIN ☐ MENOPAULSAL SYMPTOMS	*NEUROLOGICAL* ☐ FREQUENT HEADACHES ☐ NUMBNESS OR TINGLING ☐ WEAKNESS ☐ DIZZINESS	☐ *ALL SYSTEMS NEGATIVE*

FOR STAFF USE ONLY:

Date of last annual exam: _____

Date of last pap smear: _____

Date of last HPV test: _____

Prior HPV vaccine: ☐ Yes ☐ No

Blood pressure _____/_____

Weight _____ Height _____

Date of last mammogram: _____

SBE: ☐ Yes ☐ No

Date of last Dexa: _____

Gravida: _____ Para: _____

Pregnancy Test: ☐ Yes ☐ No

Medications:

Allergies: