



# Women's OB/Gyn Center

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NAME: \_\_\_\_\_

AGE: \_\_\_\_\_

MAIN REASON FOR YOUR VISIT TODAY: \_\_\_\_\_

### HISTORY OF PREGNANCIES:

YEAR:	TERM OR PREMATURE:		VAGINAL OR CESAREAN DELIVERY:	
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DATE OF LAST MENSTRUAL PERIOD: \_\_\_\_\_ HOW LONG DO THEY LAST: \_\_\_\_\_

### DO YOU EXPERIENCE ANY OF THE FOLLOWING:

	<u>YES</u>	<u>NO</u>
BLEEDING BETWEEN PERIODS :	<input type="checkbox"/>	<input type="checkbox"/>
HEAVY PERIODS:	<input type="checkbox"/>	<input type="checkbox"/>
PAINFUL PERIODS:	<input type="checkbox"/>	<input type="checkbox"/>
EXCESSIVE DISCHARGE BETWEEN PERIODS:	<input type="checkbox"/>	<input type="checkbox"/>
VAGINAL ITCHING:	<input type="checkbox"/>	<input type="checkbox"/>
SPOTTING AFTER INTERCOURSE:	<input type="checkbox"/>	<input type="checkbox"/>
PAINFUL INTERCOURSE:	<input type="checkbox"/>	<input type="checkbox"/>
PAIN WITH URINATION:	<input type="checkbox"/>	<input type="checkbox"/>
FREQUENT URINATION:	<input type="checkbox"/>	<input type="checkbox"/>
PRESSURE AT THE END OF URINATING:	<input type="checkbox"/>	<input type="checkbox"/>
URGE TO GO:	<input type="checkbox"/>	<input type="checkbox"/>
LOSS OF URINE WITH LAUGH/COUGH:	<input type="checkbox"/>	<input type="checkbox"/>
BOWEL PROBLEMS:	<input type="checkbox"/>	<input type="checkbox"/>

WHAT BIRTH CONTROL DO YOU USE: \_\_\_\_\_

HOW LONG HAVE YOU USED THIS METHOD: \_\_\_\_\_

LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING: \_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATIONS: \_\_\_\_\_

LIST ANY OPERATIONS YOU HAVE HAD:

YEAR:

OPERATION:

_____	_____
_____	_____
_____	_____

YEAR OF YOUR LAST PAP SMEAR \_\_\_\_\_ MAMMOGRAM \_\_\_\_\_

HAVE YOU OR YOUR FAMILY EVER HAD THE FOLLOWING:

	<u>YOU</u>	<u>FAMILY</u>
CANCER (LIST TYPE) _____	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
VENEREAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>
THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY DISEASES	<input type="checkbox"/>	<input type="checkbox"/>
GENETIC DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
DISABILITIES	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU HAVE ANY MEDICAL PROBLEMS NOT LISTED THAT WE SHOULD BE AWARE OF?

DO YOU SMOKE: YES  NO  IF YES HOW MANY PER DAY \_\_\_\_\_ AGE STARTED \_\_\_\_\_

DO YOU DRINK ALCOHOL?  YES  NO IF YES HOW OFTEN \_\_\_\_\_

DO YOU USE STREET DRUGS?  YES  NO