

CHENA *Obstetrics & Gynecology*

HISTORY & PHYSICAL

Date: _____ Date of Birth: _____
 Name: _____
 SS#: _____ Insurance: _____
 Address: _____
 Phone (Home): _____ Phone (Work): _____
 Occupation: _____
 Preferred Pharmacy: _____
 Chief Complaint: _____

HOSPITALIZATION OR SURGERY:

Date: _____ Reason: _____

PRIMARY CARE PROVIDER:

CURRENT MEDICATIONS: (dose and reason):

DRUG ALLERGIES: (include reaction): None

| | |
|--|--|
| | |
| | |

| Year of Last | Year of Last | Year of Last | Year of Last | Year of Last |
|-------------------|--------------|-------------------|------------------|----------------|
| Tetanus Vaccine | Mammogram | EKG/ Stress Test | Bone Scan (DEXA) | Total Physical |
| Flu Vaccine | PAP Smear | Stool/Colonoscopy | Eye Exam | |
| Pneumonia Vaccine | HPV Vaccine | Cholesterol Test | Dental Exam | |

REVIEW OF SYSTEMS

Have you had any of the following in the last 6 months?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Weight Loss/Gain | <input type="checkbox"/> Seizures | <input type="checkbox"/> Bloody Stool | <input type="checkbox"/> Pain/Bleeding after sex |
| <input type="checkbox"/> Appetite Loss | <input type="checkbox"/> Numbness/Nerve Pain | <input type="checkbox"/> Nausea/Vomiting/Heartburn | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Frequent Bruises/Easy Bleeding | <input type="checkbox"/> Constipation | <input type="checkbox"/> Abnormal Vaginal Symptoms |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Swelling of Legs | <input type="checkbox"/> Abnormal Thirst | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Depression (crying, moodiness) |
| <input type="checkbox"/> Trouble Walking | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Pain with Urination | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Wheezing/Shortness of Breath | <input type="checkbox"/> Urine Incontinence/Dribbling | <input type="checkbox"/> Sleep Difficulty |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Spitting up Blood | <input type="checkbox"/> Rash/Skin Lesions/MRSA | <input type="checkbox"/> Do you Feel Safe At Home? |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Discharge from Skin/Breasts | <input type="checkbox"/> Birth Control Method _____ |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Masses on Skin/Breast | |

Menstrual Flow: Regular Irregular Pain/Cramps Absent Since _____
 1st Date of Last Period _____ Days of Flow _____ # of Days Between Menses _____
 Pregnancies: _____ Miscarriages: _____ Induced Abortions: _____ Living Children: _____

PERSONAL HISTORY

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Arthritis/Joint Pain |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Bowel Trouble | <input type="checkbox"/> Headaches: Type _____ |
| <input type="checkbox"/> Chronic Lung Disease | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer: Type/When _____ |
| <input type="checkbox"/> Depression/Anxiety/Mental Illness | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Abnormal PAP: Type/When _____ |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Ulcers/Reflux | <input type="checkbox"/> Stroke/Heart Attack | <input type="checkbox"/> Hormone/Oral Contraceptive Use: Type _____ |
| <input type="checkbox"/> Anemia/Blood Transfusion | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fracture/Osteoporosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart Trouble/Murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia/Bronchitis | |

FAMILY HISTORY

(Please specify which blood relative and age, if still alive or age at time of death)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke/Heart Attack | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness/Depression | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> Liver Disease | |

HABITS

- | | | |
|---|--|---|
| <input type="checkbox"/> Alcohol: Type _____ Amount _____ | <input type="checkbox"/> Safety: Seat Belt Use _____ Y/N | <input type="checkbox"/> Calcium: Milk Servings/Day _____ Supplement _____ |
| <input type="checkbox"/> Drug Use: Type _____ Amount _____ How Long? _____ | <input type="checkbox"/> Fire Alarms in Home _____ Y/N | |
| <input type="checkbox"/> Tobacco: Type _____ Amount _____ How Long? _____ | <input type="checkbox"/> Exercise Routine: _____ | |
| Interested in Stopping _____ Y/N | <input type="checkbox"/> Diet: Salt Intake/Day _____ Fat Intake/Day _____ Fruits/Vegetable Servings/ Day _____ | |