EASTOVER OBGYN ANNUAL PHYSICAL REVIEW

Name: _____ **Preferred Name**: _____

Reason for Visit: _____ **Primary Care Doctor:** _____

Age: _____Occupation: _____ **Allergies:** _____

Relationship Status: (circle) Married Separated Divorced Widowed Single Committed Relationship
Are you currently sexually active? _____ Number of current partners _____ With Men, Women, or Both _____

Menstrual periods: First day of last period _____ #Days between 1st day of each period _____
#Days of Flow _____ Heavy, normal, or light _____

Pregnancy: # Total pregnancies _____ #Fullterm_____ #Preterm_____ #Living children_____
Vaginal Deliveries _____ # C-Sections _____ # miscarriages _____ # abortions _____
Complications: _____

What are you using to prevent pregnancy? (circle all that apply)
Natural family planning • Condoms • Diaphragm • Pills • Patch • Nuvaring • Depo Provera
Nexplanon • IUD • Tubal ligation • ESSURE • Vasectomy • Hysterectomy • Abstinence

Medical History: Please check if you have ever had any of the following:

☐ Abnormal pap smear	☐ High blood pressure	☐ Thyroid disorder	☐ Blood clot	Other (list):
☐ Sexually transmitted disease	☐ High cholesterol	☐ Kidney disease	☐ Migraines	
☐ Pelvic infection	☐ Diabetes	☐ Depression	☐ Infertility	
☐ Fibroids	☐ Heart disease	☐ Cancer	☐ Alcoholism	
☐ Polycystic Ovary Syndrome	☐ Lung disease	☐ Liver disease	☐ Drug addiction	

Surgical History: Please list any and all surgeries that you have had in the past (write on back for more space)

_____

Medications: Please list medications that you take on a daily basis (write on back if you need more space)

_____

Vaccinations: Have you had any of the following vaccinations?

☐ Gardasil (HPV) ☐ Flu (within 1 year) ☐ Hepatitis B ☐ Varicella (chicken pox)

Health Maintenance:

When was your last pap smear (cervical cancer screening)? _____

Have you ever had an abnormal pap? _____If so, what kind of treatment did you have? _____

When was your last mammogram: _____ When was your last colonoscopy: _____

When was your last bone scan (DEXA): _____

Have you ever smoked? _____ Do you currently smoke? _____ How much and for how long? _____

Do you drink alcohol? _____ How much and how often? _____

Do you use any other drugs? _____

Do you exercise? _____ How often? _____

Do you feel safe at home and in your relationship? _____ Have you ever been abused? _____

Family: Does anyone in your family (Grandparents, parents, siblings, or children) have any of the following illnesses?
☐ Breast Cancer ☐ Ovarian Cancer ☐ Uterine Cancer ☐ Cervix Cancer ☐ Colon Cancer ☐ Other cancer _____
☐ High blood pressure ☐ Heart attack ☐ Diabetes ☐ Stroke ☐ Alcoholism ☐ Birth defects ☐ Mental retardation
☐ Other_____