## DEKALB WOMEN'S SPECIALISTS

**Name**: _____ **Birth date**: ___/___/___ **Date:** ___/___/___

| PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING: | | | |
|---|---|---|---|
| Drug Name | Dosage | Directions | Physician |
| | | | |
| | | | |
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| | | | |

| Allergies to Medications / Substances (Latex)? | List: |
|---|---|

**CHECK IF YOU OR A BLOOD RELATIVE HAS HAD:**

| MAJOR ILLNESSES | YES | Self, Mother, Father, etc. |
|---|---|---|
| Alzheimer's Disease | | |
| Arthritis | | |
| Bowel Disease (what type?) | | |
| Breast Cancer | | |
| Cancer (what type?) | | |
| Colon polyps | | |
| Chronic Lung Disease | | |
| Deep Vein Thrombosis / Pulmonary Embolism | | |
| Depression / Mental illness / Suicide | | |
| Diabetes | | |
| Glaucoma | | |
| Heart Disease | | |
| Hepatitis / Liver disease | | |
| High Blood Pressure | | |
| High Cholesterol | | |
| Osteoporosis | | |
| Stroke | | |
| Thyroid Disease | | |
| OTHER: | | |

**SURGERY HISTORY**

| Procedure | Date of Procedure | Reason for Procedure |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**GYN HISTORY**

| Do you use birth control? □ Yes □ No | |
|---|---|
| □ Condoms | □ Nuvaring |
| □ Depo Provera | □ Birth Control Patch |
| □ Diaphragm | □ Essure |
| □ IUD- Kind | □ Natural Family Plan / Rhythm |
| - Date Inserted: | □ Tubal Ligation |
| □ Birth Control Pill | □ Vasectomy |
| - Name: | □ Withdrawal |
| □ Contraceptive Foam / Jelly | □ None: |

**Name**: _____ **Birth date**: ___/___/___ **Date:** ___/___/___

| |
|---|
| What age did you have your first period: |
| How many days are there from start of period to start of next period? _____ days |
| How long does your period last? _____ days Flow: ☐ Light ☐ Medium ☐ Heavy |
| Do you have clots? ☐ Yes ☐ No Do you have bleeding between periods? ☐ Yes ☐ No |
| Do you have cramps? ☐ No ☐ Mild ☐ Moderate ☐ Severe Do you have pelvic pain at other times? ☐ Yes ☐ No |
| Have you gone through menopause? ☐ Yes ☐ No At what age? _____ |
| Have you ever had a mammogram? ☐ Yes ☐ No When was your last mammogram performed? _____ |

## YOUR OB HISTORY

| | NUMBER | | NUMBER |
|---|---|---|---|
| Total # of Pregnancies | | Full term births | |
| Premature | | Abortions Induced | |
| Miscarriages | | Living children | |

On the chart below, please fill in answers for each pregnancy, including abortions and miscarriages.

**Do Not Complete This Portion If You Have Had A Sterilization Procedure (Essure or Tubal Ligation) or Have Had A Hysterectomy**

| No. | Birth Date | Wks Gest | Baby's Weight | Sex of Baby | Del Type Vag /CSection | Early Labor? | Wt Gain | Comments/ Complications | Location |
|---|---|---|---|---|---|---|---|---|---|
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## SOCIAL HISTORY

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|---|
| PLEASE LIST HABITS |
| Do you use a seat belt? ☐ Yes ☐ No |
| Do you perform self breast exams? ☐ Yes ☐ No |
| Do you drink milk? ☐ Yes ☐ No How many servings per day? _____ |
| Do you eat cheese or other dairy products? ☐ Yes ☐ No How many servings per day? _____ |
| Do you take calcium? ☐ Yes ☐ No Name and Dosage: _____ |
| Do you exercise? ☐ None ☐ Less than 3 times per week ☐ More than three times per week |
| Are you sexually active? ☐ Yes ☐ No<br>Do you have sex with: ☐ Husband ☐ Men ☐ Women ☐ Both |
| New sexual partner? ☐ Yes ☐ No How long? _____ Age at first intercourse? _____ |
| Lifetime sexual partners? ☐ One ☐ Less than 5 ☐ More than 5 |
| Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Engaged |
| Smoking: ☐ Yes ☐ No Packs per day? _____ Number of years _____ |
| Alcohol: ☐ Yes ☐ No Drinks per day? _____ Drinks per week? _____ |
| Drug Use: ☐ Yes ☐ No Kind? _____ Frequency? _____ |
| History of abuse? ☐ Yes ☐ No ☐ Physical ☐ Emotional ☐ Sexual |
| List of all natural or herbal remedies, over the counter drugs, vitamins, minerals etc. List: |
| Occupation: |
| Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ Other |