Lake Oswego GYN
Personalized Care for Women

RM:
WWE:_____
NP-WWE:_____

_____

Ht:_____
Wt:_____
BMI:_____
BP:_____
P: _____R:_____

CONFIDENTIAL HEALTH HISTORY

TODAY'S DATE:_____

PATIENT NAME:_____DOB:_____AGE:_____

Are there any health concerns or problems you wish to discuss with your doctor today?_____

_____

WOULD YOU LIKE A CHAPERONE PRESENT DURING YOUR EXAM? _____

DO YOU ALLOW THE DOCTOR TO VIEW YOUR PRESCIPTION HISTORY IF NEEDED?_____

CURRENT PRIMARY CARE PROVIDER _____

HOW DID YOU HEAR ABOUT OUR CLINIC?_____

PERSONAL PAST MEDICAL HISTORY

Please check any **diagnosed** medical conditions or problems.

___NONE ___Anemia ___Asthma/Lung Problems ___Bladder Problems

___Blood Clotting Disorder ___Cancer (type:_____) ___Depression ___Diabetes (type:_____)

___Eating Disorder ___Eye Problem ___Fracture (if within the last 5 yrs) ___Gallbladder/Liver Problem

___Heart Disease ___High Blood Pressure ___High Cholesterol ___Kidney Problem

___Major Infections (TB, Hepatitis, HIV, etc) ___Migraines/Severe Headaches ___Osteoporosis

___Other Psychiatric Problems ___Seizures ___Stomach or Bowel Problem ___Stroke

___Thyroid Disorder ___OTHER:_____

FAMILY MEDICAL HISTORY (see separate form for family cancer history)

Please specify which family member and which side of your family (maternal or paternal)

Relation		Relation	
Anesthetic Reaction	_____	Osteoporosis	_____
Thyroid disorder	_____	Diabetes (specify type)	_____
Heart Disease	_____	Alcoholism/Addiction	_____
Inherited Disease(s)	_____	Other (specify)	_____

SCREENING STUDIES

Please indicate dates to the best of your ability.

Date/Provider

Date/Provider

PAP Smear:_____

Mammogram:_____

Abnormal pap smear:_____

Colonoscopy:_____

Bone Density:_____

Cholesterol Panel:_____

Eye Exam:_____

Gardasil (HPV) Series:_____

PAST SURGICAL HISTORY

Please list ALL surgeries (e.g. C-sections, hysterectomy, abortion, hip replacement, etc.)

___NO SURGICAL HISTORY

Surgery or Procedure	Date	Performed by	Reason/outcome

MEDICATIONS

*Please include **ALL** over-the-counter, prescription, alternative and herbal products.*

___NO MEDICATIONS

Medication name and dose	Instructions	Prescribed by

ALLERGIES

*Please list allergies to all products, **including** medications, food and environmental allergens.*

___NO KNOWN ALLERGIES

Medication name	Reaction	Food/Environmental	Reaction

GYNECOLOGIC HISTORY Last Menstrual Period (*first day*):_____ Periods occur: Every_____days (ex. 28 days)

Period length (flow days):_____days

Average flow: ___Light ___Medium ___Heavy

Age at first period:_____

INFECTION HISTORY Dates Dates

___Chlamydia_____ ___Herpes_____

___Gonorrhea_____ ___Other_____

BREAST HEALTH HISTORY

Have you ever had a breast biopsy?_____ Results:_____

Hold old were you at first live birth?_____ Have you ever used hormone replacement therapy?_____

What is your Race/Ethnicity?_____

OBSTETRIC HISTORY

Total Pregnancies:_____Premature:_____Abortions:_____Miscarriages:_____Living:_____

Child(rens) names and ages:_____

_____

SOCIAL HISTORY

___Single ___Married ___In a Relationship ___Divorced ___Separated ___Widowed

Do you feel safe in your current relationship?_____

Are you sexually active: ___Yes ___No With: ___Male ___Female ___Both

Number of sexual partners in the last: 1 year_____ 3 years:_____ Other:_____

Birth Control Method (Please circle) Pills, IUD-type_____, Condom, Withdrawal, Nexplanon, Tubal Ligation, Vasectomy, Spermicides, Natural Family Planning, None

Occupation:_____

Education Level: ___None ___Grade School ___High School ___College

Alcohol: ___None ___Drinks per week

Tobacco: ___Never ___Current – how much? _____ ___Former (age you started____, age you quit____)

Caffeine: ___None ___Yes, Cups per day: coffee_____ tea_____ soda/pop_____

Recreational Drugs:___None ___Prescription Medication ___Other(s):_____

____Marijuana products – what and how often?_____

Exercise: ___None ___Once weekly or less ___1-3 times weekly ___4 or more times weekly

Review of Symptoms (Please check all that currently apply)

General	NO	YES
Weight Gain/loss		
Change in Strength		
Change in Energy level		
Head		
Headaches		
Vertigo		
Head injuries		
Eyes		
Change in vision		
Ears		
Change in hearing		
Nose		
Nose bleeds		
Abnormal discharge		
Mouth		
Dental difficulties		
Gum bleeding		
Neck		
Stiffness		
Breast		
Lumps		
Tenderness		
Swelling		
Nipple discharge		
Chest		
Shortness of breath		
Wheezing		
Coughing up blood		
Cough		
Psychiatric		
Depressive symptoms		
Change in sleep habits		
Change in thought content		

Heart	NO	YES
Chest Pain		
Palpitations		
Fainting		
Abdomen		
Change in appetite		
Difficulty swallowing		
Abdominal pain		
Change in bowels		
Vomiting		
Genitourinary		
Urinary Leaking		
Urinary urgency		
Painful urination		
GYN		
Menopausal symptoms		
Sexuality Concerns		
Change in periods		
Painful Cramping		
Vaginal discharge		
Pelvic Pain		
Painful sex		
Vaginal dryness		
Musculoskeletal		
Pain in muscles/joints		
Limitation in range of motion		
Numbness		
Neurologic		
Weakness		
Tremors		
Seizures		
Loss of coordination		