COLUMBUS METROPOLITAN OBSTETRICS AND GYNECOLOGY

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Date of Visit: ______________________________________
Patient's legal name: ________________________________
Chosen name: ______________________________________
Preferred Pronoun: _________Sex assigned at birth:_______
Primary Care Provider: _____________________________
Referred by:

- Physician: _________________________________
- Family Friend: ____________________________
- Other: ____________________________________

New Patient OR **Current Patient**

REASON FOR VISIT

- Annual
- Problem: __________________________________

Age: __________

Pregnancy History:

- Number of pregnancies: _______________________
- Number of Cesareans: ________________________
- Miscarriage:_______________________________
- Ectopic:___________________________________
- Abortion: __________________________________
- Live Birth: _____________ Stillbirth: ____________
- Living Children: _____________________________

Menstrual/Sexual History:

- Age menses started: ____________
- Regular monthly cycles: YES or NO; every ____ days
- First day of last menstrual period: _______________
- Sexual Preference: ___________________________
- Current contraception: _______________________
- Previous STIs: _______________________________

Preventative Care:

- Date of last pap smear: ________________________
- Previous abnormal pap: YES or NO
- Gardasil vaccination: YES or NO
- Date of last mammogram: ______________________
- Date of last colonoscopy: ________Cologuard:______
- Date of last DEXA (bone scan): _________________

Medical History (*please list all illnesses*)

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____
____
____

Surgical History (*please include year*)

____
____
____
____

Drug Allergies (*please list reaction*) ***LATEX ALLERGY***

____
____
____

Medications (*please list doses and frequency*)

____
____
____
____

Social History:

- Relationship Status:____________________________
- Tobacco use: YES or NO? # packs/day:_____________
- Alcohol use: YES or NO? # drinks/day: ____________
- Occupation: __________________________________

Family History (*please check if parents, children, siblings, grandparents, aunts/uncles or cousins AND LIST AGE)*

- Breast Cancer
- Ovarian Cancer
- Endometrial Cancer
- Cervical Cancer
- Colon Cancer
- Prostate Cancer
- Cancer (Other):__________
- Cardiovascular Disease
- Stroke
- Diabetes
- Blood Clots/Bleeding Disorder
- Thyroid Disease
- Ashkenazi Jewish Ancestry
- Other: ____________________

Review of Systems (*please check if you are* ***currently*** *experiencing)*

- Fever/chills
- Change in weight
- Extreme fatigue
- Changes in vision/hearing
- Chest pain/palpitation
- Shortness of breath/wheezing
- Swollen legs/pain in legs
- Nausea/vomiting
- Diarrhea/constipation
- Bloody stool/urine
- Painful/frequent urination
- Other:_________________
- Urinary incontinence
- Vaginal discharge
- Abnormal bleeding
- Menstrual cramps
- Pain/bleeding with sex
- Sexual difficulties
- Breast lumps/pain
- Rashes/changes in moles
- Muscle weakness
- Joint pain
- Numbness/tingling
- Anxiety/depression

Reviewed by:

______________________________________**MD/DO/CNP**

Columbus Metropolitan
Obstetrics & Gynecology