# *PIEDMONT HEALTHCARE FOR WOMEN, PA*

**GREENSBORO OB-GYN ASSOCIATES DIVISION**
510 NORTH ELAM AVENUE, SUITE 101
GREENSBORO, NC 27403
**PHONE (336) 854-8800 • FAX (336) 299-4308**

DATE ________________

BY __________________________

YOUR APPOINTMENT IS WITH DR. __________________________ ON ____________________________________
AT ______________________. PLEASE COMPLETE ALL THE INFORMATION AND BRING IT WITH YOU ON YOUR APPOINTMENT DATE.

NAME ____________________________________________ BIRTHDATE ___________________ RACE __________
RELIGION __________ HEIGHT _________ STREET ______________________ PHONE ______________________
CITY __________________________ STATE _______ ZIP CODE _________
BIRTHPLACE _____________ EMPLOYER _______________ HOURS ______ BUSINESS PHONE _____________
LEVEL OF EDUCATION ____________________ CURRENT JOB ________________________________________
HUSBAND'S NAME ________________________ EMPLOYER _______________________ PHONE _____________
NAME OF NEAREST RELATIVE ___________________ RELATIONSHIP ____________ ADDRESS ______________
PHONE _________________ HOSPITALIZATION INS. CO. _________________ CONTRACT NO. ______________
GROUP NO. ___________________ SUBSCRIBER'S NAME _________________ REFERRED BY _______________
PATIENT'S SOCIAL SECURITY # ________________________ HUSBAND'S SOCIAL SECURITY # ______________

**CONFIDENTIAL RECORD: Information will not be released unless you authorize us to do so.**

## HEALTH HISTORY

First day of last menstrual period ____________________

Age menstrual period began ____________________

Are your menstrual periods regular? ________________

How often do your periods occur? _________________

How many days do you flow? ___________________

Is your flow: ____Heavy ____Medium ____Light

Do you have painful periods? ___________________

If yes: ____Mild ____Moderate ____Severe

Do you pass blood clots with your period? ___________

Do you have vaginal bleeding between your periods?

______Yes ______No

What form of birth control do you use?

None ____ Pills ____ IUD ____ Diaphragm ____

Condoms ____ Withdrawal ____ Rhythm ____

Tubal Ligation ____ Vasectomy ____ Other ____

Do you have more than one sex partner? ____________

How many sex partners have you had? ____________

Sexual preference: Male ____ Female ____ Both ____

Have you ever had an abnormal Pap test?

____No ____Yes Explain ___________________

Date of last Pap test ___________________________

Do you have problems with vaginal discharge? ______________

Odor? ____________ Itching? ______________________

Do you have pain or bleeding with intercourse? ____________

Are you having any sexual difficulties? _________________

Have you ever been sexually or physically abused? __________

How many times have you been pregnant? _______________

How many children do you have living? ________________

How many miscarriages or terminations have you had? ______

How long ago was your last pregnancy? ________________

Have you ever had a Cesarean Section? ________________

Did you have any of the following problems in pregnancy?

High Blood Pressure ___________________________

Anemia ___________________________________

Bladder Infection ______________________________

Kidney Infection ______________________________

Seizures __________________________________

Diabetes __________________________________

Other ____________________________________

Describe __________________________________

HISTORY OF PREVIOUS PREGNANCIES:

| Date | Place of Delivery | Miscarriage or Abortion | Weeks Carried | Vaginal Delivery | Cesarean Section | Birth Weight | Born Alive or Dead | Complications |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

Have you ever been hospitalized for any condition other than pregnancy? ______Yes ______No

PLEASE LIST:

| Operation or Illness | Date | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

| | YES | NO |
|---|---|---|
| Have you ever had a blood transfusion? | ______ | ______ |
| Are you taking any medications? | ______ | ______ |
| Are you allergic to any medications? | ______ | ______ |
| Do you smoke? | ______ | ______ |
| Do you drink alcohol? | ______ | ______ |
| Do you use street drugs? | ______ | ______ |

List medication, dose & frequency: ______________

______________________________

______________________________

List medication and reaction: ______________

______________________________

______________________________

How much? ______________________________

How long? ______________________________

Marijuana ______________
Cocaine ______________
Heroin ______________
Crack ______________
Ice ______________
LSD ______________
Other ______________

Have you had or have you been vaccinated for:
German measles?____Measles?____Chicken Pox?____Tetanus?____

Have you ever been diagnosed with any sexually transmitted infections?
Chlamydia____Gonorrhea____Herpes____Syphilis____Trichomonas____Condylomata (genital warts) ____HIV ____

## Have you ever had any of the following problems?

| CARDIOVASCULAR | YES |
| --- | --- |
| Chest Pain | ______ |
| Shortness of Breath | ______ |
| Heart Murmur | ______ |
| Rheumatic Fever | ______ |
| High Blood Pressure | ______ |
| Can you walk up two flights of stairs without: | |
| a. chest pain? | ______ |
| b. shortness of breath? | ______ |
| Mitral Valve Prolapse | ______ |

| PULMONARY | |
| --- | --- |
| Pneumonia | ______ |
| Tuberculosis | ______ |
| Cough | ______ |

| GASTRO-INTESTINAL | |
| --- | --- |
| Abdominal pain | ______ |
| Poor appetite | ______ |
| Heartburn | ______ |
| Nausea | ______ |
| Vomiting | ______ |
| Diarrhea | ______ |
| Constipation | ______ |
| Bloody stools or vomitus | ______ |
| Hemorrhoids | ______ |
| Gallbladder problems | ______ |
| Hepatitis | ______ |
| Ulcers | ______ |
| Bowel habit changes | ______ |

| URINARY | |
| --- | --- |
| Pain with urination | ______ |
| Frequency (more than 7 times/day) | ______ |
| Urgency (sudden desire to urinate) | ______ |
| Dribbling | ______ |
| Blood in urine | ______ |
| Loss of urine with coughing or sneezing | ______ |
| Feelings of incomplete emptying | ______ |
| Nocturia (urinate at night) | ______ |

| NEUROLOGICAL | YES |
| --- | --- |
| Fainting | ______ |
| Seizures | ______ |
| Weakness or paralysis | ______ |
| Abnormalities of sensation | ______ |
| Abnormalities of coordination | ______ |
| Tremors | ______ |
| Loss of memory | ______ |
| Dizziness | ______ |

| ENDOCRINE | |
| --- | --- |
| Thyroid enlargement or tenderness | ______ |
| Heat or cold intolerance | ______ |
| Weight change | ______ |
| Diabetes | ______ |
| Changes in facial or body hair | ______ |

| HEAD AND NECK | |
| --- | --- |
| Frequent or unusual headaches | ______ |
| Blurring of vision | ______ |
| Eye pain | ______ |
| Hearing loss | ______ |
| Ringing in ears | ______ |
| Hoarseness or change in voice | ______ |
| Bleeding or swelling of gums | ______ |
| Lumps in neck | ______ |

| MUSCULOSKELETAL | |
| --- | --- |
| Joint stiffness or pain | ______ |
| Restriction of motion | ______ |
| Swelling | ______ |
| Bone deformity | ______ |

| PSYCHIATRIC | |
| --- | --- |
| Depression | ______ |
| Mood changes | ______ |
| Difficulty concentrating | ______ |
| Sleep disturbances | ______ |

| GENERAL | |
| --- | --- |
| Fatigue | ______ |
| Tendency to bruise easily | ______ |
| Breast lumps | ______ |
| Swelling in neck, under arms or in groin | ______ |
| Night Sweats | ______ |
| Fever or Chills | ______ |

Do any of your blood relatives have:

| | Yes | No | Who | Age at Onset |
| --- | --- | --- | --- | --- |
| Diabetes | | | | |
| Heart Disease | | | | |
| Heart Attacks | | | | |
| High Blood Pressure | | | | |
| Cancer | | | | |
| Birth Defects | | | | |
| Mental Retardation | | | | |
| Kidney Disease | | | | |
| Muscular Disorders | | | | |
| Epilepsy | | | | |
| Nervous/Mental Disorders | | | | |

## REASON FOR VISIT

Please list any problems that you want to discuss at your visit: ______________________________

______________________________

______________________________

How long has this problem been present? ______________________________

Have you had any treatment for this problem before? ______________________________