Women's Care FLORIDA
North Florida Ob-Gyn

St. Vincent South II Division
4203 Belfort Road Suite 305 Phone: (904) 738-7692

Patient's Name_____ **DOB:** _____/_____/_____ **Date:** _____
Age:_____ **Race** _____ **Referred by:** _____
Reason for this Appt_____

Menstrual History

Have you ever had an abnormal pap? ___yes ____no **Date:**____
Last Period _____ **Age at onset** _____ **Regular**⍞ Yes⍞ No **Flow**⍞ Light ⍞ Mod ⍞ Heavy
Cycle Length _____ days (from start to start) Duration: _____ days **Postmenopausal** ⍞ Yes ⍞ No
Last Mammogram_____, **Last Bone Density**_____, **Last Colonoscopy**_____
Date of last Pap smear: _____ **Current Birth Control Method** _____

⍞ Bleeding between menses ⍞ Vaginal discharge ⍞ PMS
⍞ Bleeding after intercourse ⍞ Vaginal irritation ⍞ Large Clots
⍞ Night Sweats / Hot Flashes ⍞ Irregular Bleeding ⍞ Pains / Cramps
⍞ Other: _____

Family History: Please √ if any of these have been found in any of your close relatives (parents, grandparents, brother, sister or children)

	Whom?		Whom?		Whom?
High Blood Pressure		Tuberculosis		**Cancer**	
Kidney Problems		Alzheimer's / Dementia		Breast/Age	
High Cholesterol		Depression / Suicide		Melanoma	
Diabetes		Blood Clots		Ovarian	
Heart Disease		Osteoporosis		Colon	
Stroke		Birth Defect		Other	

Allergies

Item	Reaction

Medication

Drug	Dose	How Often

Medication

Drug	Dose	How Often

Past Medical History: Have you ever had any of the following illnesses? Check all that apply.

⍞ Heart Trouble ⍞ Osteoporosis ⍞ Chronic Fatigue ⍞ Breast Problems / Nipple Discharge
⍞ Kidney / Bladder Problems ⍞ DES exposure ⍞ Anemia ⍞ Hemorrhoids
⍞ High Blood Pressure ⍞ Dysplasia / HPV ⍞ Cholesterol ⍞ Anesthesia Problems
⍞ Low Blood Pressure ⍞ Fibroids ⍞ Hepatitis ⍞ Heart Murmur / MVP
⍞ Thyroid Problems ⍞ Pelvic Prolapse ⍞ Anxiety ⍞ Antibiotics for Dental work
⍞ Migraine Headaches ⍞ Depression ⍞ Varicose Veins ⍞ Polycystic ovarian syndrome
⍞ Rectal Bleeding ⍞ Endometriosis ⍞ Diabetes ⍞
⍞ Stomach Trouble /Ulcer/ IBS ⍞ Seizures ⍞ Blood Disorders ⍞

STD type ___Chlamydia____Gonorrhea___Hepatitis___HIV___Syphillis___Genital warts____Genital Herpes

Have you ever had a blood transfusion? ⍞ Yes ⍞ No ⍞ Cancer (type) _____
Are you willing to have a blood transfusion in order to save your life?⍞ Yes ⍞ No ⍞ Other _____

Surgical History: (Including Hospitalizations)

Date	Procedure

Pregnancies _____ **Miscarriages** _____ **Abortions**____

Date	Delivery Type	Sex	Lbs/Oz	Complications

Social History: **Use of alcohol**⍞ Never⍞ Daily ⍞ Moderate **Cigarettes**_____ packs per day **Drugs**⍞ Yes ⍞ No
Marital History: ⍞ Married ⍞ Single ⍞ Separated ⍞ Divorced ⍞ Widowed
Currently sexually active ⍞ No ⍞ Yes / **With opposite sex**⍞ **Same sex**⍞ / **Same Partner** ⍞ Yes ⍞ No
History of Domestic Abuse:⍞ No ⍞ Yes explain: _____