Women's Care FLORIDA
North Florida Ob-Gyn

ST VINCENT I
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FIRST NAME _____ LAST NAME _____ MI ___ DOB ___/___/___ AGE _____ DATE ___/___/___
ADDRESS _____ DAYTIME # _____ ALTERNATE # _____ RACE _____
REASON FOR THIS APPOINTMENT _____

MENSTRUAL HISTORY:

FIRST DAY OF YOUR LAST PERIOD ___/___/___
WAS IT NORMAL FOR YOU? ☐NO ☐YES
HOW LONG DO THEY LAST? _____ DAYS
HOW MANY DAYS IS YOUR CYCLE (FROM START TO START)? _____ DAYS
HOW OLD WERE YOU WHEN YOU STARTED YOUR PERIODS? _____ YRS. OLD
PAIN/CRAMPS? ☐NO ☐YES

BLEEDING BETWEEN PERIODS ☐NO ☐YES
VAGINAL DISCHARGE ☐NO ☐YES
VAGINAL ITCHING ☐NO ☐YES
PAIN WITH INTERCOURSE ☐NO ☐YES
BLEEDING WITH INTERCOURSE ☐NO ☐YES

OBSTETRICAL HISTORY:

HOW MANY TOTAL PREGNANCIES HAVE YOU HAD? _____
HOW MANY CHILDREN DID YOU DELIVER? _____
HOW MANY MISCARRIAGES HAVE YOU HAD? _____

BIRTH CONTROL METHOD: (CIRCLE ONE)

PILLS (NAME) _____ DEPO-PROVERA
NORPLANT CONDOMS DIAPHRAGM SPERMICIDES
VASECTOMY ABSTINENCE TRYING TO CONCEIVE
OTHER _____

DO YOU HAVE OR EVER HAD:

☐DIABETES
☐HEART PROBLEMS
☐HIGH BLOOD PRESSURE
☐KIDNEY/BLADDER PROBLEMS
☐LUNG PROBLEMS
☐CANCER (TYPE _____)
☐NERVOUS BREAKDOWN
☐SHORTNESS OF BREATH
☐VISUAL DISTURBANCES
☐CHLAMYDIA
☐GONORRHEA
☐GENITAL HERPES
☐HPV (HUMAN PAPILLOMA VIRUS)
☐PNEUMONIA
☐POLIO OR MENINGITIS
☐GALL BLADDER DISEASE
☐LOSS OF BLADDER CONTROL
☐SWELLING OF HANDS/FEET
☐JAUNDICE
☐ANEMIA
☐EPILEPSY
☐CONVULSIONS
☐CHEST PAIN
☐NIGHT SWEATS
☐FAINTING SPELLS
☐SKIN DISEASE
☐CHRONIC COUGH
☐VEIN PROBLEMS
☐STOMACH TROUBLE
☐BOWEL PROBLEMS
☐RECTAL BLEEDING
☐HEADACHES
☐THYROID TROUBLE
☐HEPATITIS
☐OTHER _____

MEDICATION:

ARE YOU ALLERGIC TO ANY MEDICATIONS ☐NONE KNOWN ☐YES
IF SO WHAT NAME AND WHAT REACTION? _____
WHAT ARE YOU CURRENTLY TAKING (RS & OVER THE COUNTER)? _____

VACCINATIONS: (WHEN) INFLUENZA _____ GARDASIL _____ PNEUMOVAX _____

SURGERIES: (WHEN, WHAT, WHY) _____
_____

SOCIAL HISTORY:

MARITAL STATUS ☐ MARRIED (HOW LONG _____) ☐SINGLE ☐ DIVORCED ☐WIDOWED
USE OF ALCOHOLIC BEVERAGES ☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ NEVER
DO YOU SMOKE? ☐NO ☐YES HOW MANY PER DAY _____ HOW LONG? _____

PAP SMEAR HISTORY:

WHEN WAS YOUR LAST PAP? ___/___/___ ☐ NEVER WAS IT NORMAL? ☐NO ☐ YES
HAVE YOU EVER HAD AN ABNORMAL ONE? ☐NO ☐ YES WHAT? _____

MAMMOGRAM HISTORY:

WHEN WAS YOUR LAST MAMMOGRAM? ___/___/___ ☐ NEVER WAS IT NORMAL? ☐ NO ☐YES
HAVE YOU EVER HAD BREAST PROBLEMS? ☐ NO ☐YES WHAT? _____

FAMILY HISTORY: (HAS ANY OF YOUR BLOOD RELATIVES HAD ANY OF THE FOLLOWING)

	WHO		WHO
☐DIABETES	_____	☐HEART TROUBLE	_____
☐HIGH BLOOD PRESSURE	_____	☐KIDNEY TROUBLE	_____
☐LUNG DISORDER	_____	☐CANCER (BREAST, OVARIAN, UTERINE ,COLON, ETC.)	_____

OFFICE USE ONLY

G _____ P _____ A _____ BP _____/_____ WT _____LBS HT _____ UA _____
REMARKS: