ALL CHILDREN'S OBSTETRICS AND GYNECOLOGY SPECIALISTS

Follow-Up Health Assessment Intake

Name_____DOB_____Date_____
Age_____Marital Status_____Occupation_____
Pharmacy_____phone#_____address_____

What is the reason for your appointment today?
□ Yearly exam
□ Other _____
What questions do you have for your health care provider today? _____
_____

Allergies

Please list any allergies or reactions to medications: □ **None**

Medications	Reaction

Current Medications

(including hormones, vitamins, herbs, nonprescription medications)

Drug Name	Dosage	Date started	Drug Name	Dosage	Date started

MEDICAL/SURGICAL HISTORY
Since your last visit here, have you had any major health problems or surgery? □ no □yes
If yes, explain:_____

FAMILY HISTORY
Please note any changes in the health of your family since your last visit: □**None** _____
_____

LIFE STYLE
Do you currently smoke cigarettes? □ no, never □ have exposure to second hand smoke
□ yes, date started _____Amount/PPD _____
□ quit, date started _____Amount/PPD _____Date stopped_____
How many alcoholic drinks do you have in an average week? □ none □ #_____
What recreational drugs are you currently using, if any? □ none _____

SEXUAL HISTORY
Are you currently sexually active? □ no □ yes Are your partner(s) □ male □ female

Do you or your partner have more than one partner? □ no □ yes □ don't know
Do you want to be screened for any sexually transmitted infections or HIV/AIDS? □ no □ yes □ unsure
What methods, if any, do you use to protect against pregnancy?_____
Are you planning a pregnancy in the next year? □ no □ yes

Diet, Exercise & Habits

Caffeine Intake: □ None □ Coffee/tea/soda _____ cups/day
Weight : Are you satisfied with your weight? □ Yes □ No
Diet: How do you rate your diet? □ Good □ Fair □ Poor
Do you eat or drink four servings of dairy or take calcium supplements? □ Yes □ No
Exercise: Do you exercise regularly? □ Yes □ No
What kind of exercise? _____
How long (minutes) _____ How often? _____
If you do not exercise, why? _____
Safety:
Do you use seatbelts consistently? □ Yes □ No
Domestic violence including emotional, physical, and sexual abuse is a serious health threat to women, is anyone hurting you now in any way?_____

Review of Systems
Please check any current symptoms you have

Constitutional: □ Fevers/chills/excessive sweating □ Unexplained weight loss/gain/fatigue
Gastrointestinal: □ abdominal pain □ nausea/vomiting/diarrhea □ constipation □ blood in stools
Eyes/ears/nose/throat: □ vision changes □ hearing loss □ mouth breathing/snoring
□ difficulty hearing/ringing in ears □ hayfever/allergies/congestion
Genitourinary: □ concern with sexual function □vaginal discharge □painful or bloody urination
□ leaking urine
Cardiovascular: □shortness of breath □palpitations
Skin: □rashes □ new or change in mole □ acne
Psychiatric: □Anxiety/depression □insomnia/nightmares □bad temper/angry outbursts
Blood/Lymph: □unexplained lumps □ easy bruising/bleeding
Respiratory: □cough / wheeze
Neurological: □ headaches □ fainting □ memory loss
Musculoskeletal: □ muscle/joint pain or edema □ Recent back pain
Breast: □ lumps or masses □ nipple discharge □ painful breasts

Date of last: Mammogram_____Colonoscopy_____Cholesterol screen_____
Tetanus_____Pap Smear_____Dental Check_____

Primary Care Provider_____Phone #_____
Address_____
□ If you would like a copy of today's visit sent to your PCP, please sign below.

Signature_____ Date_____