Patient Name: _____

DOB: _____ Date: _____

Seasons OB/GYN

1-855-281-4963

PERSONAL INFORMATION

Family Doctor:	Referred by:
Reason for visit:	

MENSTRUAL STATUS

Last Period:	Having periods: Yes No	If no, Reason:

ALLERGIES

Allergies	Reaction	Noted

MEDICATION DOCUMENTATION (PRESCRIBED, HERBAL, OVER-THE-COUNTER)

Medication Name	Dosing and Instructions	Start Date

PREGNANCY

Date	Weeks Gestation	Weight	Labor Length	Sex	Type of Delivery	Complications

PERSONAL MEDICAL HISTORY

◯ NEUROLOGICAL	◯ DVT (BLOOD CLOT)	◯ DOMESTIC VIOLENCE	◯ COLON CANCER
◯ HEART DISEASE	◯ BREAST PROBLEMS	◯ PELVIC PAIN	◯ BREAST CANCER
◯ HIGH BLOOD PRESSURE	◯ BEHAVIORAL/PSYCHIATRY	◯ INFERTILITY	◯ UTERINE CANCER
◯ LUNG DISEASE	◯ URINARY DISEASE	◯ ENDOMETRIOSIS	◯ OVARIAN CANCER
◯ DIABETES MELLITUS	◯ BLOOD DISEASE	◯ CHICKEN POX/SHINGLES	◯ CERVICAL CANCER
◯ THYROID DISEASE	◯ LIVER DISEASE/HEPATITIS	◯ UTERINE FIBROIDS	◯ OTHER CANCER
◯ GASTROINTESTINAL	◯ ANESTHETIC COMPLICATIONS	◯ OTHER	

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SURGICAL HISTORY Please check boxes

◯ C-SECTION WHEN:	◯ D&C WHEN:	◯ LEEP WHEN:
◯ HYSTERECTOMY ◯ Abdominal ◯ Vaginal WHEN: OVARIES REMOVED: YES NO	◯ TUBAL LIGATION: WHEN:	◯ LAPAROSCOPY WHEN:
◯ BLADDER CONTROL SURGERY WHEN:	◯ REMOVAL OF FIBROIDS (MYOMECTOMY) WHEN:	◯ APPENDECTOMY WHEN:
◯ GALLBLADDER REMOVED WHEN:	◯ TONSILLECTOMY ADENOIDECTOMY WHEN:	
◯ ENDOMETRIAL ABLATION WHEN:	◯ BLOOD TRANSFUSION WHEN:	
◯ **PLEASE LIST ANY OTHER SURGERIES YOU HAVE HAD:**		

SOCIAL HISTORY

TOBACCO USE: YES NO	HOW MANY PACKS/DAY?	FOR HOW MANY YEARS?	READY TO QUIT? YES NO	DATE QUIT?
SMOKELESS TOBACCO USE? YES NO				
ALCOHOL USE? YES NO	AMOUNT/TYPE/HOW OFTEN?			
DRUG USE? YES NO	AMOUNT/TYPE/HOW OFTEN?			
OCCUPATION:	MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOW / SEPERATED / OTHER			

DIET & EXERCISE

DIET INFORMATION/CONCERNS: YES NO	
EXERCISE (SPECIFY TYPE/AMOUNT): YES NO	

SEXUALITY

SEXUALLY ACTIVE: YES NO	PARTNER MALE FEMALE	BIRTH CONTROL: YES NO	TYPE:

FAMILY HISTORY Does anyone in your family have these conditions? Check yes or no to the best following for your blood relatives (mother, father, brothers, sisters, sons, daughters, aunts, uncles, grandparents), DO NOT INCLUDE YOURSELF.

RELATIONSHIP	No Known Problems	Add Problem	Uterine Cancer	Colon Cancer	Clotting Disorder	Breast Cancer	Cancer	Diabetes	Heart Disease	Hyperlipidemia	Hypertension	Ovarian Cancer	Osteoporosis	Stroke	Thyroid Disease	Transplant	Ovarian Cysts
MOTHER																	
FATHER																	
SISTER																	
BROTHER																	
MAT AUNT																	
MAT UNCLE																	
PAT AUNT																	
PAT UNCLE																	
MGM																	
MGF																	
PGM																	
PGF																	
OTHER																	

( ) I AM ADOPTED AND DO NOT KNOW MY FAMILY HISTORY

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GYNECOLOGICAL HISTORY

AGE OF FIRST PERIOD:	
PERIOD FREQUENCY:	
HOW LONG DOES YOUR PERIODS LAST:	
PAINFUL MENSTRUAL CRAMPS:	YES/MILD YES/MODERATE YES/SEVERE NO
HEAVY MENSTRUAL FLOW: YES NO	IRREGULAR FLOW: YES NO
DOES YOUR MENSTRUAL FLOW AFFECT THE QUALITY OF YOUR LIFE? YES NO	
ANY NEW PARTNERS SINCE LAST EXAM? YES NO	DO YOU WANT STD TESTING? YES NO
STD HISTORY: NO HISTORY GONORRHEA CHLAMYDIA HERPES HPV GENITAL WARTS HIV HEPATITIS C	
URINARY MENOPAUSE SEXUALITY	
URINE LEAK WITH COUGH/SNEEZE	YES NO
URINE LEAK WITHOUT COUGH/SNEEZE	YES NO
PAINFUL URINATION	YES NO
NIGHT TIME URINATION	YES NO
FREQUENT URINATION	YES NO
VAGINAL DISCHARGE	YES NO
HOT FLASHES	YES NO
DRY SKIN	YES NO
DECREASED SEX DRIVE	YES NO
DECREASED ORGASM/VAGINAL DRYNESS	YES NO
DATE OF LAST PAP SMEAR:	HPV DONE? YES NO
DATE OF LAST MAMMOGRAM:	HAVE YOU EVER HAD AN ABNORMAL MAMMOGRAM? YES NO
DATE OF LAST COLONOSCOPY:	DATE OF LAST BONE DESITY SCAN:
IN A LIFE SAVING SITUATION WOULD YOU ACCEPT A BLOOD TRANSFUSION? YES NO MAYBE	

IMMUNIZATION HISTORY

HAVE YOU BEEN VACCINATED FOR HEPATITIS B?	YES NO	IF YES, WHEN:
HAVE YOU BEEN VACCINATED FOR INFLUENZA?	YES NO	IF YES, WHEN:
HAVE YOU BEEN VACCINATED FOR HPV (Gardasil)?	YES NO	IF YES, WHEN:
HAVE YOU BEEN VACCINATED FOR TDAP?	YES NO	IF YES, WHEN:

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REVIEW OF SYSTEMS (circle all that apply to you currently or recently) □ I am having none of the following symptoms

CONSTITUTIONAL:			MUSCULOSKELETAL:		
Lack of energy	Weight loss	Weight gain	Muscle pain	Joint pain	Arthritis
Trouble sleeping	Fevers	Poor appetite	Osteopenia	Osteoporosis	Back pain
EYES:			NEUROLOGICAL:		
Vision changes	Blurring	Glaucoma	Numbness	Headache	Dizziness
EARS/NOSE/THROAT/MOUTH:			PHYCHIATRIC:		
Drainage	Discharge	Soreness	Depression	Anxiety	Excessive mood swings
Pain	Lumps	Trouble swallowing	Disorientation	PMS symptoms	
GASTROINTESTINAL:			ENDOCRINE:		
Nausea	Vomiting	Constipation	Hot flashes	Cold intolerance	Excessive thirst
Bloody or black stools	Diarrhea	Change in stools	Period irregularity	Painful periods	Absence of periods
Bloating	Abdominal pain	Hemorrhoids	Heavy periods	Frequent periods	
RESPIRATORY:			HEMATOLOGIC/LYMPHATIC:		
Cough	Shortness of breath	Wheezing	Anemia	Easy bruisability	Swollen glands
Pain with breathing	Sputum		Swollen legs	Pain under arms	Swollen lymph nodes
CARDIOVASCULAR:			ALLERGY/IMMUNE:		
Chest pain	Angina	Leg pain	Seasonal allegies	Difficulty healing	Steroid use
Irregular heart beat	Palpitations	Fluid retention	New drug allergy	Frequent illness	
GENITOURINARY:			BREAST/SKIN:		
Burning with urination	Urgency or frequent urination		Breast lump	Milky breast discharge	Breast pain
Vulvar/vaginal llump lesion	Incontinence	Vulvar redness	Breast discharge	Rash	Change in moles
Vulvar/vaginal swelling	Blood in urine	Vulvar/vaginal itching	Itching	New skin lesion	

Provider Reviewed by: _____ Date: _____

Rev. 3/17