Baptist
Physician Network
Obstetrics & Gynecology
Performing Sacred Work Every Day

Name: ___________________________________ Date of Birth: ______________________

Reason for your visit today: ____

How long has this been a problem: ____

Have you been treated for this problem by another provider in the past? ( ) Yes ( ) No

If so, who treated you and what was done? _____________________________________

Please note any other conditions for which you see a doctor:

_____High Blood Pressure	_____Kidney Disease	_____Heart Disease
_____Diabetes	_____Dialysis	_____Heart Valve Disease
_____Stroke	_____Blood Clot/DVT	_____History of Blood Thinners
_____High Cholesterol	_____Seizures	_____Crohns Disease
_____Liver Disease	_____HIV/ AIDS	_____Stent Placement (Cardiac or other)
_____Acid Reflux	_____Heart Rhythm	
_____Asthma	_____Thyroid (Hyper/Hypo)	
_____Ulcerative Colitis	_____COPD	

_____History of Cancer? If yes, where: ____

Please list any other conditions: ____
____
____
____

Gynecologic History:
Number of pregnancies _____ Age when first child born_____
Method of delivery ( ) Natural ( ) C-Section
Date of last menstrual period or age of menopause_____________
Age of menarche (starting cycle) _______________

List all prior surgical procedures and hospitalizations with approximate dates: _______________
____
____
____
____

Do you take blood thinners? (Aspirin, Plavix, Coumadin/Warfarin) ( ) Yes ( ) No

Current Medications (please list all prescribed, herbal and over the counter medications along with dosage):____
____

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Allergies: ____
____

Social History
Are you currently employed? (   ) Yes (   ) No   if so, what is your occupation(s)? ____________
if disabled, please list the nature of your disability_________________________
Do you use tobacco products? (   ) Yes (   ) No if yes, number of packs per day______________
number of years________________
Do you drink regularly? (   ) Yes (   ) No if yes, please list amount: ________________________
Do you use illicit drugs? (   ) Yes (   ) No if yes, please list: ______________________________
Marital Status:_____Single ______Married _____Widowed _____Divorced
Please list any major illnesses or causes of death in your family members:
Mother: ____
____
Father:____
____
M Grandparents: ____
____
P Grandparents: ____
____
Brothers: ____
____
Sisters:____
____

Review of Symptoms: (**Please circle any symptoms you are currently experiencing**)

General:	Anorexia, chills, fatigue, weight loss/amount _______
Ophthalmologic:	Blurred vision, diminished visual acuity, eye pain
HEENT:	Headache, decreased hearing, difficulty swallowing, sinus congestion, sore throat, swollen glands
Endocrine:	Cold intolerance, excessive thirst, heat intolerance
Respiratory:	Cough, shortness of breath at rest, shortness of breath with exertion
Cardiovascular:	Heartburn, chest pain/pressure, edema, palpitations, weakness
Gastrointestinal:	Dark/tarry stools, incontinence, abdominal pain, blood in stool, constipation, diarrhea, difficulty swallowing, nausea, vomiting
Women Only:	Irregular menses, vaginal discharge/itching
Genitourinary:	Blood in urine, difficulty urinating, frequent urination, painful urination
Musculoskeletal:	Arthritis, painful joints, swollen joints, muscle weakness
Skin:	Easy bleeding, jaundice, easy bruising, dry skin, rash
Neurologic:	Dizziness, fainting, headache, seizures, tingling/numbness
Psychiatric:	Bipolar disorder, mania, anxiety, depressed mood, suicidal thoughts