Partners in Obstetrics & Gynecology

a division of Southern New England Healthcare for Women, LLC.
333 SCHOOL STREET
PAWTUCKET, RI 02860

Today's Date: _____

Last Name: _____ **First Name:** _____ **Date of Birth**: _____

Important: In order to provide the highest quality health care possible, it is important that we have the following information. Please answer all the questions as accurately as possible. If you do not understand the question, please ask for assistance. Thank you.

PHARMACY _____ **PHARMACY PHONE** _____

Address _____ City _____ State _____ Zip _____

PRIMARY CARE PHYSICIAN _____ **PCP PHONE:** _____

Address _____ City _____ State _____ Zip _____

TELLS US ABOUT OTHER PHYSICIANS WHO YOU MAY SEE:

PHYSICIAN _____ **SPECIALTY:** _____ _____

Phone: _____ Address _____

PHYSICIAN _____ **SPECIALTY:** _____ _____

Phone: _____ Address _____

LIST ANY ALLERGIES: _____

_____

LIST ALL MEDICATIONS: PRESCRIBED, OVER THE COUNTER AND HERBAL

May we have your permission to contact your insurance to obtain a list of the medications you have had filled during the last 13 months? YES NO

MEDICATION/DOSE/FREQUENCY	MEDICATION/DOSE/FREQUENCY

Last Name: _____ **First Name:** _____ **Date of Birth**: _____

GYN HISTORY

Age your period began:							
Date of Last Pap Smear							
Have you ever had an abnormal pap smear?	Yes	No					
Are you sexually active?	Yes	No	If Yes,	Men	Women	Both	
Current Birth Control Method							
Have you ever been diagnosed with any sexually transmitted infection or disease?							
Have you had an HPV vaccine?							
If Post Menopausal, Age at Menopause							
Are you currently taking any Hormone Replacement Therapy medications?	Yes	No	Have you ever taken any Hormone Replacement Therapy medications?			Yes	No
Have you had any post menopausal bleeding?	Yes	No					
Date of Last Mammogram:							
Date of Last Colonoscopy:							
Date of most recent bone density?							

OBSTETRICAL HISTORY

Have you ever been pregnant? (Including termination of pregnancy) YES NO

How many times have you been pregnant? _____

□ number of full-term delivery(s) _____ □ number of premature delivery(s) _____

□ number of terminations/abortions _____ □ number of miscarriages _____

□ number of tubal pregnancies _____ □ number of twins/triplets _____

How many children living? _____

Last Name: _____ **First Name:** _____ **Date of Birth**: _____

PAST PREGNANCIES

	Delivery Date	# of Fetus	Weight	Sex	Delivery Type	Full-term or Pre-mature	Complications during pregnancy or delivery
1							
2							
3							
4							
5							
6							

PAST MEDICAL HISTORY: Circle all that apply.

Arthritis	Yes No	GI Problems (please specify)	Yes No
Acid Reflux(GERD)	Yes No	GYN Cancer(please specify)	Yes No
AIDS/HIV	Yes No	Headaches/Migraines	Yes No
Anemia	Yes No	Heart Problems	Yes No
Anxiety/Depression	Yes No	Hematologic Disorders(please specify)	Yes No
Asthma	Yes No	Hepatitis	Yes No
Bladder Disorder (please specify)	Yes No	High Cholesterol	Yes No
Breast Cancer	Yes No	High Blood Pressure	Yes No
Cancer (please specify)	Yes No	Kidney Disorder(please specify)	Yes No
Coronary Artery Disease	Yes No	Lung Disease(please specify)	Yes No
Diabetes	Yes No	Osteoporosis/Osteopenia	Yes No
DVT/PE	Yes No	Psychiatric Illness	Yes No
Endometriosis	Yes No	Stroke	Yes No
Glaucoma	Yes No	Thrombophilia	Yes No
Fibromyalgia	Yes No	Thyroid Disorder	Yes No
Other			

SURGICAL HISTORY – Please list any surgery you may have had in the past.

Type of Surgery	Date of Surgery

Last Name: _____ **First Name:** _____ **Date of Birth**: _____

FAMILY HISTORY

Mother □ Living □ Deceased - Cause and Age at death: _____

Father □ Living □ Deceased - Cause and Age at death: _____

Number of Siblings: _____ Living _____ Deceased _____ Cause _____

Has any of your blood relative(s) had the following, also specify the age and relationship:

	Yes/No	Relative		Yes/No	Relative
Ovarian Cancer			High Blood Pressure		
Uterine Cancer			Kidney Disease		
Colon Cancer			Hyperlipidemia		
Breast Cancer			Diabetes		
Melanoma			Depression		
Prostate Cancer			Bipolar Disorder		
Heart Disease			Stroke		
Thyroid Disease			Osteoporosis		
Other					

SOCIAL HISTORY

Occupation: _____

Level of Education: _____

Marital Status: (circle one) Single Married Divorced Separated Widowed Domestic Partner

Exercise Level: (circle one) None Occasional Moderate Heavy

Smoking Status: (circle one) Never a smoker Former Smoker Smoker Have been smoking since ____years old

Alcohol Intake: (circle one) None Occasional Moderate Heavy

Do you use illicit drugs? No Yes _____

Have you ever had abuse or domestic violence directed at you: No Yes

Do you routinely use a seat belt? No Yes Do you use sunscreen regularly? No Yes

Is a blood transfusion acceptable in an emergency? No Yes

Do you have an advanced directive? No Yes