THE CENTER FOR WOMEN
OBSTETRICS & GYNECOLOGY
J Harley Barrow Jr MD & Amanda G Thornton APN
628 Hospital Drive #2A – Mountain Home AR 72653
(870) 425-7300 / (870) 425-4431 fax

FEMALE MEDICAL HISTORY FORM FOR NEW GYN & ANNUAL PATIENTS

Name: _____Date of Birth: _____ Today's Date: _____

Social History:
( ) I smoke cigarettes/cigars/vape ( ) I am sexually active ( ) I have completed my family

Any known **drug/environmental (i.e. tape/adhesive) allergies:** _____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No
If yes, please explain: _____

Medications currently taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Age of First Menstrual Cycle: _____ Last Menstrual Period: _____ Total Pregnancies: _____
#Living Children: _____/ #Full Term Preg: _____/ #Pre-Term Preg: _____/ #Induced Abortions: _____/ #Miscarries: _____

PREVENTATIVE MEDICAL CARE:
Date of last pap smear: _____
Was it normal: ( ) YES ( ) NO
Date of last Mammogram: _____
Was it normal: ( ) YES ( ) NO
Date of last BMD (bone mineral density): _____
Was it normal: ( ) YES ( ) NO
Date of last Colonoscopy: _____
Was it normal: ( ) YES ( ) NO

DO YOU HAVE A HISTORY OF:
( ) Breast Cancer
( ) Uterine Cancer
( ) Ovarian Cancer
( ) None of the Above

HAVE YOU HAD:
( ) Hysterectomy with removal of ovaries
( ) Hysterectomy (removal of uterus only)
( ) Oophorectomy (removal of ovaries only)

BIRTH CONTROL METHOD
( ) Menopause
( ) Hysterectomy
( ) Tubal Ligation
( ) Birth Control Pills
( ) Vasectomy

Please mark any **MEDICAL ILLNESSES:**
( ) Osteoporosis
( ) High blood pressure
( ) High cholesterol
( ) Uterine Fibroids
( ) Polycystic Ovarian Syndrome (PCOS)
( ) Stroke and/or heart attack
( ) Heart Bypass/Heart Disease
( ) Blood clot and/or a pulmonary emboli
( ) Arrhythmia/Irregular heartbeat
( ) Any form of Hepatitis or HIV
( ) Lupus or other Autoimmune disease
( ) Fibromyalgia
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Seizure Disorder/Epilepsy
( ) Chronic Kidney Disease
( ) Diabetes
( ) Thyroid Disease
( ) Arthritis
( ) Depression/Anxiety
( ) Cancer (type): _____ & Year: _____

PLEASE COMPLETE OTHER SIDE AS WELL!

THE CENTER FOR WOMEN
OBSTETRICS & GYNECOLOGY
J Harley Barrow Jr MD & Amanda G Thornton APN
628 Hospital Drive #2A – Mountain Home AR 72653
(870) 425-7300 / (870) 425-4431 fax

FEMALE SYMPTOM ASSESSMENT CHECKLIST

Name: _____ **Date:** _____

SYMPTOMS (please check mark)	NEVER	MILD	MODERATE	SEVERE
Fatigue				
Memory Loss				
Mental Confusion				
Decreased Sex Drive or Libido				
Sleep Problems				
Mood Changes or Irritability				
Tension				
Migraines or Severe Headaches				
Difficult to Climax Sexually				
Bloating				
Weight Gain				
Breast Tenderness				
Vaginal Dryness				
Hot Flashes				
Night Sweats				
Dry or Wrinkled Skin				
Hair Falling Out				
Cold All The Time				
Swelling All Over The Body				
Joint Pain				

Please mark any FAMILY HISTORY:	Yes	No
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

PLEASE COMPLETE OTHER SIDE TOO!