

  
**The Center for Women**  
*Obstetrics & Gynecology*

Mary Wren, MD • Harley Barrow, MD • Erik Shultz, MD • Amanda Thornton, APN

628 Hospital Drive, Ste. 2A & 3E  
 Mountain Home AR 72653  
 (870) 425-7300 / (870) 424-4164 fax

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_/\_\_\_/\_\_\_ **BIRTHDATE:** \_\_\_/\_\_\_/\_\_\_

**NAME PREFERRED TO BE CALLED:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_

**REASON FOR VISIT:**  ROUTINE OB CARE  PROBLEM **DESCRIBE PROBLEM:** \_\_\_\_\_

**CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:**

MAJOR ILLNESSES	YES	NO	MAJOR ILLNESSES	YES	NO
Anemia			Hepatitis / Jaundice		
Anxiety			Herpes / HSV		
Arthritis / Joint pain			High Blood Pressure		
Asthma			High Cholesterol		
Blood transfusions			HIV / AIDS		
Bowel Trouble			HPV / Human Papilloma Virus		
Breast Cancer			Kidney Infections / Urinary Tract Infections		
Cancer			Kidney Stones		
Chicken Pox			Mood Disorders		
Chlamydia			Pneumonia		
Chronic Lung Disease			Rheumatic Fever		
Depression			Sexually Transmitted Diseases		
Diabetes			Stroke		
Eating Disorder			Syphilis		
Fracture			Tuberculosis - TB		
Glaucoma			Thyroid Disease		
Gonorrhea / GC			Ulcers		
Heart Murmur			OTHER:		
Heart Trouble					

**WHEN WAS YOUR LAST TEST OR IMMUNIZATION?**

	DATE		DATE
Bone Density		Mammogram	
Colonoscopy / Sigmoidoscopy		TB Skin Test	
Flu Shot		Last Normal PAP Smear	
Pneumonia		Last Abnormal PAP Smear	
Tetanus			

**PLEASE LIST ANY PAST INJURIES OR ILLNESSES:**

TYPE	DATE	TYPE	DATE

**PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:**

SURGERY / HOSPITALIZATION / REASON	DATE	SURGERY / HOSPITALIZATION / REASON	DATE

NAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:**

DRUG NAME	DOSAGE	PHYSICIAN	DRUG NAME	DOSAGE	PHYSICIAN
<b>ALLERGIES TO MEDICATIONS / SUBSTANCES (LATEX GLOVES, ETC.?)</b>		List:			

**CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:**

MAJOR ILLNESSES	YES	NO	WHAT BLOOD RELATIVE? Mother's / Father's
Anemia			
Arthritis / Joint pain			
Asthma			
Bowel Trouble / Ulcers			
Breast Cancer			
Cancer			
Chronic Lung Disease			
Depression / Anxiety / Mood Disorders			
Diabetes			
Glaucoma			
Heart Trouble / Murmur			
Hepatitis / Jaundice			
High Blood Pressure			
High Cholesterol			
Kidney Infections / Stones			
Stroke			
Thyroid Disease			
Tuberculosis - TB			
OTHER:			

**CIRCLE AND CHECK IF YOU, THE FATHER OF THE BABY, OR ANY BLOOD RELATIVE HAVE:**

GENETIC SCREENING	YES	NO	WHO?
Cystic fibrosis			
Down syndrome, mental retardation, autism, fragile X			
Heart defects at birth			
Hemophilia			
Huntington chorea			
Maternal metabolic disorder (insulin dependent diabetes, PKU)			
Muscular dystrophy			
Neural tube defects, spina bifida, anencephaly, menigomyelocele			
Patient or father of baby had a child with birth defects not listed above			
Recurrent pregnancy loss or a stillbirth			
Sickle cell disease or trait (African)			
Taken any medications, drugs alcohol since your last period			
Tay Sachs disease (Jewish, Cajun or French Canadian)			
Thalassemia, Italian, Greek, Mediterranean or Asian Background			
Other inherited genetic or chromosomal disorder			
What:			

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**YOUR GYN HISTORY**

Were you using any birth control when you got pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Condoms	<input type="checkbox"/> Nuvaring
<input type="checkbox"/> Depo Provera	<input type="checkbox"/> Birth Control Patch
<input type="checkbox"/> Diaphragm	<input type="checkbox"/> None
<input type="checkbox"/> IUD- Kind	<input type="checkbox"/> Natural Family Plan/Rhythm
- Date Inserted:	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Birth Control Pill	<input type="checkbox"/> Vasectomy
- Name:	<input type="checkbox"/> Withdrawal
<input type="checkbox"/> Contraceptive Foam/Jelly	<input type="checkbox"/> Other:
What age did you have your first period: _____	
How many days are there from start of your period to start of next period? _____ days	
How long does your period last? _____ days	Flow: <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy
Date of Last Period: _____	Are you sure of the date? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was it a normal period? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had a home urine pregnancy test? <input type="checkbox"/> Yes <input type="checkbox"/> No	When: _____
Have you had an office urine pregnancy test? <input type="checkbox"/> Yes <input type="checkbox"/> No	When: _____
Have you had an office blood pregnancy test? <input type="checkbox"/> Yes <input type="checkbox"/> No	When: _____
Have you had recent abnormal bleeding? <input type="checkbox"/> Yes <input type="checkbox"/> No	When: _____

**YOUR OB HISTORY**

	NUMBER		NUMBER
Total # of pregnancies		Full term births	
Premature delivery (less than 37 weeks)		Abortions / Termination	
Miscarriages		Living children	

On the chart below, please fill in answers for each pregnancy including abortions or miscarriages.

No.	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight/Sex	Del Type Vag/CSection	Epid Y / N	Preterm Labor?	Wt Gain	Comments / Complications	Hospital
1				M						
				F						
2				M						
				F						
3				M						
				F						
4				M						
				F						
5				M						
				F						
6				M						
				F						

What are some of the questions you would like answered today?


NAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SOCIAL HISTORY**

PLEASE LIST HABITS	
Do you use a seat belt?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have an infant car seat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you plan to take childbirth classes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you plan to breastfeed your baby?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you plan to have an epidural for labor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you want your tubes tied after the birth of this baby?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you have a son, do you want to have him circumcised?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you've had a Cesarean section, do you want a repeat C-Section?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you planning any out of town trips during this pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What was your pre pregnancy weight?	
Are there any religious or cultural preferences that would affect your care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What:	
What do you plan to use for contraception after the birth of your baby?	
<input type="checkbox"/> Condoms	<input type="checkbox"/> DepoProvera
<input type="checkbox"/> Foam/Jelly	<input type="checkbox"/> Nuvaring
<input type="checkbox"/> Vasectomy	<input type="checkbox"/> Withdrawal
<input type="checkbox"/> Diaphragm	<input type="checkbox"/> Birth Control Patch
<input type="checkbox"/> IUD	<input type="checkbox"/> None
<input type="checkbox"/> Birth Control Pill	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Natural Family Planning/Rhythm	<input type="checkbox"/> Other
Do you have a pediatrician?	<input type="checkbox"/> Yes <input type="checkbox"/> No Who?
Do you have a cat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you clean the litter box?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you do a Self Breast Exam?	<input type="checkbox"/> Yes <input type="checkbox"/> No How often:
Do you Drink Milk?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glasses per day:	
Do you Eat Cheese or other Dairy products?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Servings per day:	
Do you Take Calcium?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name and Dosage:	
Do you Exercise?	<input type="checkbox"/> None <input type="checkbox"/> Less than 3 times per week <input type="checkbox"/> More than 3 times per week
Do you have sex with?	<input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both
First Intercourse at Age:	New sexual partner? <input type="checkbox"/> Yes <input type="checkbox"/> No
Lifetime sexual partners	<input type="checkbox"/> Less than 5 <input type="checkbox"/> More than 5
Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously
Packs per day:	Number of Years: Stopped Years ago
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously
Drinks per day:	Drink per week:
Drug User	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously
Kind:	Frequency:
History of abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Physical	<input type="checkbox"/> Emotional <input type="checkbox"/> Sexual
List all "Natural" or Herbal remedies, over the counter drugs, vitamins or minerals you are taking.	List:
Occupation:	
Race	<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed

NAME: \_\_\_\_\_

BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

**REVIEW OF SYSTEMS:**  
Please Check (X) If Any Of The Following Applies To You NOW.

<b>CONSTITUTIONAL</b>	<b>NOTES</b>	<b>GENITOURINARY (CONT)</b>	<b>NOTES</b>
Weight Loss <input type="checkbox"/>		Decreased sex drive <input type="checkbox"/>	
Weight Gain <input type="checkbox"/>		Painful intercourse <input type="checkbox"/>	
Fever <input type="checkbox"/>		Possible Pregnancy <input type="checkbox"/>	
Fatigue <input type="checkbox"/>		Genital Sores <input type="checkbox"/>	
Night Sweats <input type="checkbox"/>			
Hot Flashes <input type="checkbox"/>			
<b>EYES</b>		<b>SKIN</b>	
Double vision <input type="checkbox"/>		Rashes <input type="checkbox"/>	
Vision changes <input type="checkbox"/>		Itching <input type="checkbox"/>	
		Skin Dryness <input type="checkbox"/>	
<b>HENT</b>		Skin Lesions <input type="checkbox"/>	
Headaches <input type="checkbox"/>		Changes to Lesions or Moles <input type="checkbox"/>	
Dizziness <input type="checkbox"/>		Acne <input type="checkbox"/>	
Sore Throat <input type="checkbox"/>			
Sinus Pain <input type="checkbox"/>		<b>NEUROLOGICAL</b>	
Nose Bleeding <input type="checkbox"/>		Muscular Weakness <input type="checkbox"/>	
Thyroid Mass <input type="checkbox"/>		Numbness or Tingling <input type="checkbox"/>	
Neck Pain <input type="checkbox"/>		Difficulty Concentrating <input type="checkbox"/>	
<b>BREAST</b>		Memory Difficulties <input type="checkbox"/>	
Lumps <input type="checkbox"/>		Speech Difficulties <input type="checkbox"/>	
Tenderness <input type="checkbox"/>		Seizures <input type="checkbox"/>	
Swelling <input type="checkbox"/>		Loss of Balance <input type="checkbox"/>	
Discharge <input type="checkbox"/>			
Pain in Breast <input type="checkbox"/>		<b>MUSCULOSKELETAL</b>	
Abn Changes in Breast <input type="checkbox"/>		Joint Pain or Swelling <input type="checkbox"/>	
		Muscle Pain <input type="checkbox"/>	
<b>CARDIOVASCULAR</b>		Back Pain <input type="checkbox"/>	
Chest Pain <input type="checkbox"/>			
Irregular Heart Beats <input type="checkbox"/>		<b>ENDOCRINE</b>	
Rapid Heart Rate <input type="checkbox"/>		Loss of Hair <input type="checkbox"/>	
Fainting <input type="checkbox"/>		Difficulty Tolerating Cold <input type="checkbox"/>	
Swelling of legs <input type="checkbox"/>		Difficulty Tolerating Heat <input type="checkbox"/>	
Varicose veins <input type="checkbox"/>			
<b>RESPIRATORY</b>		<b>PSYCHIATRIC</b>	
Wheezing <input type="checkbox"/>		Anxiety <input type="checkbox"/>	
Cough <input type="checkbox"/>		Depression <input type="checkbox"/>	
Shortness of breath <input type="checkbox"/>		Impulsive Behavior <input type="checkbox"/>	
Spitting up blood <input type="checkbox"/>		Suicidal Thoughts <input type="checkbox"/>	
		Excessive Anger <input type="checkbox"/>	
<b>GASTROINTESTINAL</b>		Mood Swings <input type="checkbox"/>	
Nausea <input type="checkbox"/>		Emotional Abuse <input type="checkbox"/>	
Vomiting <input type="checkbox"/>		Physical Abuse <input type="checkbox"/>	
Diarrhea <input type="checkbox"/>		Sexual Abuse <input type="checkbox"/>	
Constipation <input type="checkbox"/>		<b>HEMATOLOGIC/ LYMPHATIC</b>	
Abdominal Pain <input type="checkbox"/>		Bruises, frequent or easily <input type="checkbox"/>	
Bloody / Black Stool <input type="checkbox"/>		Cuts do not stop bleeding <input type="checkbox"/>	
Hemorrhoids <input type="checkbox"/>		Enlarged lymph nodes <input type="checkbox"/>	
Jaundice <input type="checkbox"/>			
<b>GENITOURINARY</b>		<b>ALLERGIC/IMMUNOLOGIC</b>	
Urgency of urination <input type="checkbox"/>		Frequent illness <input type="checkbox"/>	
Frequency of urination <input type="checkbox"/>		Seasonal Allergies <input type="checkbox"/>	
Pain with urination <input type="checkbox"/>		<b>OTHER</b>	
Nighttime urination <input type="checkbox"/>		1. <input type="checkbox"/>	
Losing urine <input type="checkbox"/>		2. <input type="checkbox"/>	
Blood in urine <input type="checkbox"/>		3. <input type="checkbox"/>	