CHENA *Obstetrics & Gynecology*

HISTORY & PHYSICAL

Date:_____Date of Birth:_____
Name:_____
SS#:_____ Insurance:_____
Address:_____
Phone (Home):_____Phone (Work):_____
Occupation:_____
Preferred Pharmacy:_____
Chief Complaint:_____
DRUG ALLERGIES: (include reaction): **None** ☐

HOSPITALIZATION OR SURGERY:
Date: Reason:
_____
_____
_____
_____
PRIMARY CARE PROVIDER:_____
CURRENT MEDICATIONS: (dose and reason):
_____
_____
_____

	Year of Last		Year of Last		Year of Last		Year of Last		Year of Last
Tetanus Vaccine		Mammogram		EKG/ Stress Test		Bone Scan (DEXA)		Total Physical	
Flu Vaccine		PAP Smear		Stool/Colonoscopy		Eye Exam			
Pneumonia Vaccine		HPV Vaccine		Cholesterol Test		Dental Exam			

REVIEW OF SYSTEMS

Have you had any of the following in the last 6 months?

☐ Weight Loss/Gain	☐ Seizures	☐ Bloody Stool	☐ Pain/Bleeding after sex
☐ Appetite Loss	☐ Numbness/Nerve Pain	☐ Nausea/Vomiting/Heartburn	☐ Sexual Problems
☐ Fever	☐ Frequent Bruises/Easy Bleeding	☐ Constipation	☐ Abnormal Vaginal Symptoms
☐ Fatigue	☐ Swelling of Legs	☐ Abnormal Thirst	☐ Hot Flashes
☐ Muscle Weakness	☐ Chest Pain	☐ Blood in Urine	☐ Depression (crying, moodiness)
☐ Trouble Walking	☐ Heart Palpitations	☐ Pain with Urination	☐ Anxiety
☐ Vision Changes	☐ Wheezing/Shortness of Breath	☐ Urine Incontinence/Dribbling	☐ Sleep Difficulty
☐ Sinus Problems	☐ Spitting up Blood	☐ Rash/Skin Lesions/MRSA	☐ Do you Feel Safe At Home?
☐ Headaches/Migraines	☐ Chronic Cough	☐ Discharge from Skin/Breasts	☐ Birth Control Method_____
☐ Dizziness/Fainting	☐ Frequent Diarrhea	☐ Masses on Skin/Breast	

Menstrual Flow: ☐ Regular ☐ Irregular ☐ Pain/Cramps ☐ Absent Since_____
1st Date of Last Period_____ Days of Flow _____ # of Days Between Menses_____
Pregnancies:_____ Miscarriages:_____ Induced Abortions:_____ Living Children:_____

PERSONAL HISTORY

☐ Asthma	☐ Sexually Transmitted Disease	☐ Glaucoma	☐ Arthritis/Joint Pain
☐ Rheumatic Fever	☐ Domestic Violence	☐ Bowel Trouble	☐ Headaches: Type_____
☐ Chronic Lung Disease	☐ Sexual Abuse	☐ High Blood Pressure	☐ Cancer: Type/When_____
☐ Depression/Anxiety/Mental Illness	☐ Thyroid Disease	☐ Kidney Disease	☐ Abnormal PAP: Type/When_____
☐ Seizures/Convulsions	☐ Ulcers/Reflux	☐ Stroke/Heart Attack	☐ Hormone/Oral Contraceptive Use:
☐ Anemia/Blood Transfusion	☐ Diabetes	☐ Fracture/Osteoporosis	Type_____
☐ Heart Trouble/Murmur	☐ Hepatitis	☐ Pneumonia/Bronchitis	☐Other_____

FAMILY HISTORY

(Please specify which blood relative and age, if still alive or age at time of death)

☐ Alcoholism	☐ Seizures/Convulsions	☐ Osteoporosis	☐ Kidney Disease
☐ Bleeding Disorder	☐ Heart Disease	☐ Stroke/Heart Attack	☐ Arthritis
☐ Cancer	☐ High Blood Pressure	☐ Thyroid Disease	☐ Other:_____
☐ Diabetes	☐ Mental Illness/Depression	☐ Tuberculosis (TB)	☐ Other:_____
☐ Glaucoma	☐ Migraines/Headaches	☐ Liver Disease	

HABITS

☐ Alcohol: Type_____
Amount_____
☐ Drug Use: Type_____
Amount_____ How Long?_____
☐ Tobacco: Type_____
Amount_____ How Long?_____
Interested in Stopping……**Y/N**

☐ Safety: Seat Belt Use……**Y/N**
Fire Alarms in Home……**Y/N**
☐ Exercise Routine: _____
_____
☐ Diet: Salt Intake/Day_____
Fat Intake/Day_____
Fruits/Vegetable Servings/ Day _____

☐ Calcium: Milk Servings/Day_____
Supplement_____