

Oakdale OB/GYN

Established GYN Patient

Today's date _____

Appointment Date _____

Name: _____ Date of Birth _____

Primary Care Physician: _____

What are your primary concerns today? _____

We would like to keep your health history up to date. Please list any surgeries since you were last seen in our office.

Surgery/Reason	Date
1.	
2.	
3.	

Please list any new medical problems since you were last seen in our office.

Medical Problem/Treatment	Date of onset
1.	
2.	
3.	

Please list any changes to your FAMILY MEMBERS' health history since you were last seen in our office.

Medical Problem/Treatment	Family Member
1.	
2.	
3.	

Please list any NEW lab, mammogram, x-ray, ultrasound, colonoscopy, sigmoidoscopy, thyroid, blood sugar, cholesterol tests you have had at other offices since you were last seen here.

Test	Date	Result
Mammogram Yes No		
Colonoscopy Yes No		
Sigmoidoscopy Yes No		
Cholesterol Yes No		
Glucose Yes No		
Thyroid Yes No		
X-Ray Yes No		

Current Medications: This includes prescription and over the counter medications, vitamins, herbal medications and prescription birth control.

Medication	Dose	Medication	Dose

Allergies: Do you have any allergies, (food, medication, medical products)? Yes ___ No ___ if yes, please list below.

Allergy	Reaction

Marital Status: Single Partnered Engaged Married Divorced Widowed
Your occupation _____ Spouse/Partner Name _____
How much alcohol do you drink in a typical week?
Do you smoke? Never Quit Yes How many per day?
Do you want help to quit? Yes No
How much do you exercise? 1x week 1-3x week 4 or more x week no formal exercise
How much calcium (servings or milligrams) do you get in a day?
Do you always wear a seat belt? Yes No
Would you like to be tested at your visit today for sexually transmitted infections? Yes No
Are you afraid of your spouse/partner/significant other/any family member? Yes No

Gynecological (skip this section if you are in menopause)

Flow: None Light Medium Heavy
Cramps: None Mild Moderate Severe
Bleeding between periods? Yes No
Have you had any pregnancies since you were last seen at Oakdale OBGYN?
Date of Last menstrual period?
Method of birth control?

Patient Signature _____

MD/CNP Signature _____ Date _____

For Office Use Only ___ Verified Health History ___ Updated Greenway