**Azalea Gynecology • 1814 New Hanover Medical Park Drive • Wilmington, NC 28403**

## ESTABLISHED PATIENT HISTORY

**Allergies:**

Name: ______________________ Age: ______ Birthdate: _____/_____/_____ Today's Date: _____/_____/_____

SSN: ______________________ Primary Care Physician: ______________________ Specialist Physician: ______________________

**Please report changes or new developments as asked below:**

**Patient & Family History:** ❑ **No change since _____/_____/_____**

| | Patient | Father | Mother | Sibling | Child | MGM/GF | PGM/GF |
|---|---|---|---|---|---|---|---|
| Alcoholism | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ ❑ | ❑ ❑ |
| Asthma | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ ❑ | ❑ ❑ |
| Bleeding disorder | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ ❑ | ❑ ❑ |
| Cancer | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ ❑ | ❑ ❑ |
| Diabetes | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ ❑ | ❑ ❑ |
| Epilepsy/Seizures | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ ❑ | ❑ ❑ |
| High Cholesterol | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ ❑ | ❑ ❑ |
| Heart disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ ❑ | ❑ ❑ |

| | Patient | Father | Mother | Sibling | Child | MGM/GF | PGM/GF |
|---|---|---|---|---|---|---|---|
| High blood pressure | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ ❑ | ❑ ❑ |
| Kidney disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ ❑ | ❑ ❑ |
| Mental illness | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ ❑ | ❑ ❑ |
| Migraine | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ ❑ | ❑ ❑ |
| Osteoporosis | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ ❑ | ❑ ❑ |
| Stroke | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ ❑ | ❑ ❑ |
| Thyroid disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ ❑ | ❑ ❑ |
| Neurologic disorders | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ ❑ | ❑ ❑ |

(Key: MGM - mother's mother PGM - father's mother MGF - mother's father PGF - father's father)

**Other:** ______________________

**Surgeries:** ______________________

**Hospitalizations:** ______________________

**Social History:** ❑ **No change since ______/______/______**

Tobacco use ❑ No ❑ Yes ____________ Alcohol/Drug use ❑ No ❑ Yes ____________

Sexual Abuse ❑ No ❑ Yes ____________ Emotional Abuse ❑ No ❑ Yes ____________ Physical Abuse ❑ No ❑ Yes ____________

Diet (type/restrictions) ____________ Exercise ❑ No ❑ Yes ____________ Seat Belt Use ❑ No ❑ Yes Sunscreen use ❑ No ❑ Yes

**OB-GYN History:** ❑ **No change since last exam ______/______/______** LMP (1st day of last period) _____/_____/_____

Length of Menstrual Cycle (# of days from one cycle to next) _________ How long period lasts? ________

Menstrual Irregularities ______________________

STD's ❑ Yes ❑ No Type ____________ Abnormal paps ❑ Yes ❑ No Type ____________

Infertility ❑ Yes ❑ No Abnormal vaginal discharge ❑ Yes ❑ No Abnormal vaginal bleeding ❑ Yes ❑ No

______________________

Pregnancies: ❑ No changes _____/_____/_____ Total # pregnancies _____ # miscarriages _____ # abortions _____ # living children _____

Describe any changes:

| Date | Gest Age | Hrs Labor | Induced? | Type Del | Alive/Dead | Baby's Wt | Sex | Complications (pregnancy, labor, delivery, postpartum) |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |

**Leave this section blank to be completed by clinical staff:**

**Last Pap:** Date_______ Results ______________

**Mammogram:** Date ______ Loc _________ Results ______________

**Colorectal Screening:** Date ______ Results ______________

**Type of Birth Control:** ______________

**BSE:** ❑ Yes ❑ No FamHx Br Ca ______________

**Bone Density:** Date ______ Results ______________

**Immunizations:** ❑ Tetanus ❑ Rubella ❑ Hep B ❑ Gardasil

**Allergies:** ❑ None ______________

**Current Prescription Medication:** ______________

OTC's: ______________

MVI: ______________ Herbals: ______________

**Chief Complaint:** ______________________

## REVIEW OF SYSTEMS

**Allergies:**

Name: ______________________________________________ Age: ______Birthdate: _____/_____/_____ Today's Date: _____/_____/_____

****Please check any positive answers for symptoms persistent throughout the past year. Check the negative box if none are present.**

1. Constitutional ❑ Negative ❑ Weight loss ❑ Weight gain ❑ Fever ❑ Fatigue
   Other ____________________________________________

2. Eyes ❑ Negative ❑ Vision change ❑ Glasses/contacts
   Other ____________________________________________

3. Ears/Nose/Throat/Mouth ❑ Negative ❑ Ulcers ❑ Sinusitis ❑ Ringing in ears ❑ Headache
   Other ____________________________________________

4. Cardiovascular ❑ Negative ❑ Shortness of breath lying down ❑ Chest pain ❑ Dizziness ❑ Swelling ❑ Palpitations
   Other ____________________________________________

5. Respiratory ❑ Negative ❑ Wheezing ❑ Cough ❑ Coughing up blood ❑ Shortness of breath

6. Gastrointestinal ❑ Negative ❑ Diarrhea ❑ Bloody Stools ❑ Nausea ❑ Vomiting ❑ Pain ❑ Gas ❑ Constipation
   Other ____________________________________________

7. Genitourinary ❑ Negative ❑ Blood in urine ❑ Difficulty urinating ❑ Urgency ❑ Frequency ❑ Incomplete emptying ❑ Abnormal vaginal bleeding ❑ Incontinence ❑ Pain during sex ❑ Abnormal vaginal discharge
   Other ____________________________________________

8. Musculoskeletal ❑ Negative ❑ Muscle weakness Other ______________________________

9. Skin/Breast ❑ Negative ❑ Breast pain ❑ Discharge ❑ Masses ❑ Rash ❑ Ulcers ❑ Skin changes
   Other ____________________________________________

10. Neurological ❑ Negative ❑ Fainting ❑ Seizures ❑ Numbness ❑ Trouble Walking
    Other ____________________________________________

11. Psychiatric ❑ Negative ❑ Depression ❑ Anxiety ❑ Panic disorder ❑ Crying ❑ Mood swings
    Other ____________________________________________

12. Endocrine ❑ Negative ❑ Diabetes ❑ Hypothyroid ❑ Hyperthyroid ❑ Hair loss ❑ Hot flashes ❑ Night sweats
    Other ____________________________________________

13. Hematology/Lymphatics ❑ Negative ❑ Bruises easily ❑ Bleeds easily ❑ Anemia ❑ Enlarged lymph nodes
    Other ____________________________________________

14. Allergies ❑ Negative Other ______________________________