Contemporary Obstetrics and Gynecology, P.C.

Board Certified
Obstetrics and Gynecology
www.contemporarydoctors.com

Patient Name:_____ Date of Birth:_____ Date:_____

Referred By:_____ Age:_____

Reason for Visit: _____

_____

Menstrual History:

Date of last period: _____
Date of last pap smear: _____ Result: _____
Date of last mammogram: _____ Result: _____
Age of onset of period: _____
Is your cycle regular? **Y / N** Flow: Light / Medium / Heavy
How long does your period last? _____
How often do you get your cycle? _____
Do you bleed between periods? **Y / N**
Do you use birth control? **Y / N** If yes, what kind? _____
If using an IUD what kind do you have? _____ Date of insertion: _____
If using Nexplanon, when was it inserted? _____
Have you had a Hysterectomy? **Y / N** Date of Surgery: _____
Have you gone through Menopause? **Y / N** Age of occurrence: _____
Are you sexually active? **Y / N**

Past Medical History	Yes	No	Comments
Hypertension			
Diabetes			
Asthma			
High Cholesterol			
Endometriosis			
Stroke			
Heart Disease			
Anxiety/Depression			
Cancer			
Other			

Surgical History: Please list any surgeries/procedures	Date

Family Medical History	Yes	No	Relation and Age of Diagnosis
Breast Cancer			
Ovarian Cancer			
Colon Cancer			
Diabetes			
High Blood Pressure			
Heart Disease			
Blood Clot/DVT			
Uterus Cancer			
Cervical Cancer			
Osteoporosis			
Any other cancer (please list)			
Any other illness (please list)			

Reproductive History:

Number of Pregnancies: _____ Miscarriages: ____ Full Term: _____

Elective Abortions: ____ Ectopic: ____ Living: ____ Preterm: ____

Date of Delivery	Name	Location	Complications

Medication(s) Name:	Strength	Dose

Allergies	Reaction(s)

Social History:

Smoker? **Y / N** If yes how long have you smoked? _____ Amount per day _____
Any history of recreational drug use? **Y / N** Kind: _____ Frequency: _____
Do you exercise? **Y / N** How many days a week? _____
Do you consume alcohol? **Y / N** How many days a week? _____
Are you employed? **Y / N** Occupation: _____
Marital Status: ☐ Married ☐Separated ☐Divorced ☐Widowed ☐Single

Primary Care Physician

Name: _____Phone: _____ Fax:_____

Address: _____

The questions on this form have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes to my medical status.

Patient Signature: _____ Date: _____

Relationship to Patient (if not patient): _____