Desert Sage
Obstetrics and Gynecology

Pt's Name _____Date of Birth_____Age _____Today's Date _____
Email:_____ Pharmacy #_____

With whom may we discuss test results or therapies? _____

At what phone number can we leave a secured voice mail?_____

1. GYNECOLOGICAL HISTORY: Any gynecological problems since your last examination? ❒ Yes; ❒ No (If yes, please explain)

- First day of last period _____
- Duration of flow _____
- Time between periods _____
- Date of last Bone Density Scan _____
- Colonoscopy? ❒ Yes; ❒ No If yes, when? _____
- Date of last Mammogram _____
- Date of last Pap Smear _____
- Are you sexually active? _____
- Do you use contraception? ❒ Yes; ❒ No (If yes, type?) _____
- Are you done having children? ❒ Yes; ❒ No

2. MEDICAL HISTORY: Any medical problems since your last examination? ❒ Yes; ❒ No (If yes, please explain)

- Do you take calcium? ❒ Yes; ❒ No
- List current Medications with the dosages
  (include vitamin and herbal supplements) _____
- List any Allergies to Medication _____
- Any Surgeries/Hospitalizations since your last examination? (If yes, please explain):

3. FAMILY HISTORY: Any changes to your family history since your last examination? ❒ Yes; ❒ No (If yes, please explain)
   (For example, breast cancer, ovarian cancer, uterine cancer and/or colon cancer, > 10 polyps on colonoscopy?)
   - Ashkenazi / Jewish Ancestry? ❒ Yes; ❒ No

4. SOCIAL HISTORY: Any changes to your social history since your last examination? ❒ Yes; ❒ No

- Do you exercise regularly? ❒ Yes; ❒ No Current Occupation: _____
- Marital status? ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widow ❒ Same Sex Partner
- Do you smoke cigarettes? ❒ Yes; ❒ No If yes, at what age did you start?_____ Packs per day?_____
- Do you drink alcohol? ❒ Yes; ❒ No If yes, amount? _____ If yes, how often? _____
- Do you use drugs socially? ❒ Yes; ❒ No If yes, amount? _____ If yes, how often? _____
- Are you a victim of domestic violence or abuse in your present relationship? ❒ Yes; ❒ No Past Relationship? ❒ Yes; ❒ No
- Do you have a living will? ❒ Yes; ❒ No
- Do you have a medical power of attorney? ❒ Yes; ❒ No If yes, please supply a copy.

5. REVIEW OF SYSTEMS

Abdomen:
Diarrhea? ❒ Yes ❒ No Constipation? ❒ Yes ❒ No Other: _____

Genitourinary:
Frequent urination? ❒ Yes ❒ No Urinary Incontinence? ❒ Yes ❒ No Other: _____

Skin/breast:
Lumps in breast? ❒ Yes ❒ No Nipple discharge? ❒ Yes ❒ No Other: _____

Any other problems?

Completed by:_____Date:_____

Reviewed by: _____Date:_____
(Signature of Provider)