Northwest Gynecology Associates, LLC

Christine M. Corbin, MD

Name _____

Date of birth _____ Age _____ Today's date _____

Who is your primary care provider? _____

Who referred you to our office? _____

How can we help you?

____ Annual well-woman exam

____ Problem visit

If your visit is problem oriented, please describe the nature of your symptoms or health concerns:

_____

_____

_____

_____

_____

Medical History

Medications _____

_____

_____

Allergies _____

_____

Illnesses

____ High blood pressure
____ Diabetes
____ Lung problems
____ Depression
____ Thyroid problems
____ Other _____
____ Heart disease
____ Kidney problems
____ Stomach/bowel problems
____ Gastroesophogeal reflux (GERD)
____ Cancer

Surgical History

Type of surgery	Date of procedure
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Obstetrical History

Date of pregnancy	Pregnancy outcome	Type of delivery

Gynecologic History

Age of first period? _____ Date of last pelvic exam? _____
Describe your menstrual cycles (skip if menopausal or if you have had a hysterectomy):
Number of days between periods? _____ Number of days of flow? _____
Significant cramping? _____ Bleeding between periods? _____
How frequently do you change protection on your heaviest day of flow? _____
Any bleeding after intercourse? _____
Date of last Pap test? _____ Result? _____
Any history of abnormal Pap tests? _____
Was treatment needed? _____ Laser/LEEP/cryotherapy? _____
Are you sexually active? _____ Do you have intercourse? _____
Alternative lifestyle? _____ Do you practice safe sex? _____
Current method of birth control? _____
Previous methods of birth control? _____
Would you like to discuss contraception during your visit? _____

PMS problems?

____ Bloating	____ Weight gain	____ Breast tenderness
____ Moodiness	____ Migraines	____ Sugar cravings
____ Anxiety	____ Fatigue	____ Difficulty concentrating

Sexual concerns?

____ Pain with intercourse
____ Decreased sexual desire
____ Decreased sexual response
____ Other concerns

Do you have any history of sexually transmitted diseases?

____ Herpes
____ Gonorrhea or chlamydia
____ HPV or genital warts
____ HIV
____ Hepatitis

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For menopausal patients:

Do you currently use hormone therapy? _____
If yes, do you experience menstrual bleeding? _____
Have you used hormone therapy previously? _____
If yes, how long were you on hormones? _____
When did you discontinue hormones? _____

Review of Symptoms

Please indicate any current symptoms you are experiencing:

General

____ Weight gain
____ Change in appetite
____ Hot flashes/night sweats
____ Fatigue
____ Unusual hair growth
____ Skin changes
____ Fever/chills
____ Sleeping difficulties

Abdominal symptoms

____ Bloating
____ Cramping
____ Diarrhea
____ Constipation
____ Bloody stools
____ Heartburn
____ Food allergies

Bladder symptoms

____ Urinary urgency
____ Urinary frequency
____ Wear pads regularly for protection
____ Urinary leakage with laughing, coughing, sneezing
____ Frequency of urination at night
____ Difficulty emptying bladder
____ Incomplete bladder emptying
____ Frequent bladder infections
____ Pain with urination

Breast symptoms

____ Cyclic breast tenderness
____ Lumps or cysts
____ History of breast biopsy
____ Nipple discharge
____ Abnormal mammogram
____ Date of last mammogram

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Social History

Do you work outside the home? _____ Occupation? _____ FT/PT
Who lives at home with you? _____
Do you have elderly family members that you care for? _____
Do you use tobacco? _____ If yes,
How much do you smoke? _____
How long have you smoked? _____
Do you have any desire to quit? _____
Do you use alcohol? _____ If yes,
How often do you drink? _____
Do you drink to excess/drunkenness? _____
Do you use caffeine? _____ If yes,
How many caffeinated beverages do you consume daily? _____
Do you exercise? _____ If yes,
How often? _____
What kind of activity? _____
How long are your exercise sessions? _____

Family History

Please indicate if you have family members (biologic siblings, parents, grandparents) with any of the following:

____ High blood pressure
____ Heart disease
____ Diabetes
____ Stroke
____ Osteoporosis
____ Bleeding abnormalities
____ Substance abuse (alcohol/street drugs/prescription drugs)
____ Female family members with hysterectomies, fibroids, endometriosis
____ Cancer
- ____ Breast
- ____ Ovarian
- ____ Uterine
- ____ Cervical
- ____ Lung
- ____ Blood (leukemia/lymphoma)
- ____ Colon

Please bring this completed patient history form to your appointment. Thank you.