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

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.