

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 Heart disease
 Diabetes Kidney problems
 Lung problems Stomach/bowel problems
 Depression Gastroesophageal reflux (GERD)
 Thyroid problems Cancer
 Other _____

Surgical History

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



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

- | | |
|---|--|
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Unusual hair growth |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Skin changes |
| <input type="checkbox"/> Hot flashes/night sweats | <input type="checkbox"/> Fever/chills |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sleeping difficulties |

Abdominal symptoms

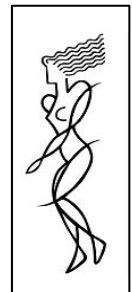
- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Bloody stools |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Food allergies |
| <input type="checkbox"/> Constipation | |

Bladder symptoms

- | | |
|--|--|
| <input type="checkbox"/> Urinary urgency | <input type="checkbox"/> Frequency of urination at night |
| <input type="checkbox"/> Urinary frequency | <input type="checkbox"/> Difficulty emptying bladder |
| <input type="checkbox"/> Wear pads regularly for protection | <input type="checkbox"/> Incomplete bladder emptying |
| <input type="checkbox"/> Urinary leakage with laughing, coughing, sneezing | <input type="checkbox"/> Frequent bladder infections |
| | <input type="checkbox"/> Pain with urination |

Breast symptoms

- | | |
|---|---|
| <input type="checkbox"/> Cyclic breast tenderness | <input type="checkbox"/> Nipple discharge |
| <input type="checkbox"/> Lumps or cysts | <input type="checkbox"/> Abnormal mammogram |
| <input type="checkbox"/> History of breast biopsy | <input type="checkbox"/> 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.

