BALCONES OB/GYN

Nancy Binford, MD

Name________________________________Date______________Date of Birth_____________Age_______

MENSTRUAL	*OBSTETRICAL*
First day of last menstrual period:	Total # of pregnancies: Total # of live births:
Age of first period:	Total # of miscarriages : Total # of abortions:
Regular cycles? ☐ Yes ☐ No	Any cesarean sections? ☐ Yes ☐ No How many?
How many days between the start of each period?	Any pregnancy complications? ☐ Yes ☐ No
Total flow : ☐ light ☐ medium ☐ heavy	Please explain:
How many days do you bleed with each period?	
Do you pass any blood clots? ☐ Yes ☐ No	
Pain/cramps? ☐ Normal ☐ Severe	
Bleeding between periods? ☐ Yes ☐ No	
Recent changes? ☐ Yes ☐ No	
Please describe:	

GYNECOLOGY

Please indicate if you have a history of any of the following:				
Abnormal Pap smears	☐ Yes	☐ No	When?	If treatment/surgery was required, what kind?
Pelvic Inflammatory Disease	☐ Yes	☐ No	When?	
Sexually Transmitted Disease	☐ Yes	☐ No	Which one?	When?
Fibrocystic Breast Condition	☐ Yes	☐ No		
What is your method of contraception?				If hormonal birth control, which one?
When was your last Pap smear?				
When was your last mammogram?		Last bone density test?		Last colonoscopy?

SURGERY	*HOSPITALIZATION*
Have you ever had surgery? ☐ Yes ☐ No List date, place, & surgery below:	Have you ever been in the hospital for an illness? ☐ Yes ☐ No List date, place, & illness below:

REVIEW OF SYSTEMS

Do you *currently* have any of these symptoms?					
Weight loss/gain	#lbs.	# months	Heartburn/bloating	☐ Yes	☐ No
Fever	☐ Yes	☐ No	Bleed easily	☐ Yes	☐ No
Night sweats/hot flashes	☐ Yes	☐ No	Bleeding from source other than vaginal	☐ Yes	☐ No
Rash	☐ Yes	☐ No	Joint pain	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Leg pain	☐ Yes	☐ No
Visual changes	☐ Yes	☐ No	Fatigue	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No	Urinary incontinence	☐ Yes	☐ No
Cough	☐ Yes	☐ No	Pain with urination	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No	Mood swings	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No	Insomnia	☐ Yes	☐ No
Back pain	☐ Yes	☐ No	Vaginal dryness	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No	Vaginal itching/irritation	☐ Yes	☐ No
Diarrhea/constipation	☐ Yes	☐ No	Vaginal discharge	☐ Yes	☐ No

SOCIAL HISTORY

Do you smoke?	If so, how many packs per day?	Are you single, married, divorced, widowed?
Do you drink alcohol?	If so, how many drinks per week?	Are you a victim of domestic violence?
Do you use drugs?	If so, what kind?	Occupation : Employer:

PERSONAL MEDICAL HISTORY

Do you have a history of any of the following?		Describe	Please name your family doctor:		Describe
Measles, chicken pox	Yes No		Blood clot in legs	Yes No	
Anemia	Yes No		Blood clot in lungs	Yes No	
Bladder/kidney disease	Yes No		Breast lump	Yes No	
Bone/joint disease	Yes No		Diabetes	Yes No	
Bowel disease	Yes No		Heart disease	Yes No	
Lung disease/asthma	Yes No		What type?		
Neurologic disease	Yes No		High blood pressure	Yes No	
Rheumatic fever	Yes No		Migraine headaches	Yes No	
Stomach ulcer/acid reflux	Yes No		Varicose veins	Yes No	
Tuberculosis	Yes No		Stroke	Yes No	
Pneumonia	Yes No		Cancer	Yes No	
Liver disease/hepatitis	Yes No		What type?	When?	
Thyroid disease	Yes No				
Depression/anxiety/other	Yes No				

FAMILY MEDICAL HISTORY

Has a close relative had a history of any of the following?		Which relative(s)? (i.e. father, maternal grandmother, etc.)	(for office use only) Fam. Hx. reviewed:
Breast cancer	Yes No		
Ovarian cancer	Yes No		
Colon cancer	Yes No		
Other cancer Type?	Yes No		
Diabetes	Yes No		
High blood pressure	Yes No		
Heart disease	Yes No		
Stroke	Yes No		
Thyroid disease	Yes No		
Osteoporosis	Yes No		

MEDICATIONS

Please list any medications you take currently including all prescribed medications as well as any over-the-counter medications for weight loss, any pain relievers (like Tylenol, ibuprofen, & aspirin), antacids, laxatives, supplements, herbal remedies, etc.

ALLERGIES

Are you allergic to any medications? Yes No
If so, please list:

IMMUNIZATIONS

Have you had the HPV vaccine (Gardasil)? Yes No If so, when?	Did you get all 3 shots within 6 months? Yes No

What is the reason for your visit today?____

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Patient/Guardian signature Date