Legacy OB/GYN

Date:_____________________________

Patient Name: _________________________________ **DOB:**____________________________________
Pharmacy: _____________________________________ **Phone No:** _________________________________
PCP:____ **Phone No:**_______________________________

Social History:

Employer/Occupation __________________________ Marital Status _______Education Level_________
Exercise Type and Frequency_____________Caffeinated beverages/day: ________Illicit Drugs Yes/No
Smoker Yes/No If yes, Cigarettes/day _______ Vape:Yes/No Alcoholic drinks/day _____ Week ______
Do you feel safe in your current relationship? Yes / No Is blood transfusion acceptable in an emergency? Yes/ No

GYN History:

If menopausal,at what age did your periods stop?_______
What was the first date of your last menstrual period? ____________Was it a normal period? Yes / No
If not, when was the last normal period? _________Length of period? ______days Regular/ Irregular?
Do you have cramps? Yes / No Are your periods usually Light/Medium/ Heavy/Clotting (circle one)
Frequency of cycles ? ___________(ex: every 28-30 days)

Would you like information on a simple safe procedure performed in our office that can significantly reduce or eliminate your monthly periods/cramps? Yes / No
Do you suffer from urinary leakage when you cough, sneeze, laugh or exercise? Yes/ No
Would you like information on a simple safe procedure performed in our office that can significantly improve urinary leakage? Yes / No

Contraception:

What is your current form of birth control? (please circle)
Abstinence Birth Control Pills Hysterectomy IUD Menopause Tubal Ligation Vasectomy
Nuvaring Patch Depo Provera Rhythm Condoms Nexplanon Nothing N/A (Same Sex Partner)
How long have you been using your current form of birth control? ___________________________
Are you planning to have another child ? _________________________My family is complete_____

Review of Symptoms: **(circle all *current* symptoms)**
General: Fatigue Fever Weight Gain_____ lbs Weight Loss____lbs
Cardiovascular: Palpitations Chest Pain
Pulmonary: Cough Shortness of Breath
Gastrointestinal: Abdominal Pain Bloating Constipation Diarrhea Hemorrhoids
Bloody Stools Nausea Vomiting
Urinary: Painful Urination Blood in urine Frequency UTIs Incontinence/Leakage
Genital: Irregular Periods Painful intercourse History of sexual abuse Pelvic Pain
Vaginal Discharge Vaginal itching Vaginal Odor
Musculoskeletal: Back pain Joint pain
Breast: How often do you perform self breast exams? Regularly/Irregularly /Never
Do you have any ? Breast Masses Breast Tenderness Nipple discharge Breast Pain
Skin: Rash Warts Abnormal Moles
Neurologic: Dizziness Headaches Difficulty concentrating
Psychiatric: Anxiety Depression PMS Insomnia
Endocrine: Hair loss Temperature intolerance Excessive hair growth
Allergies: Seasonal allergies Food Allergies Medication Allergic Reactions
Blood/Lymphatic: Bruises easy Bleeds easy History of blood transfusion Enlarged lymph nodes