Legacy OB/GYN

Date:_____

Provider (Please Circle):Dr. Melissa Bailey, Dr. Hina Khan, Dr. Alice Fa, Arden Moulin-NP, Ruth Whiddon-NP

Patient Name: _____ **DOB:**_____

Pharmacy: _____ **Phone No:** _____

PCP:_____ **Phone No:**_____

Reason for Visit:_____

Allergies to any Medication / Latex / Iodine / Other? If yes, please list allergy and reaction(s)

_____

_____

Medications and Supplements: Please list names and dosages

_____ _____ _____ _____

_____ _____ _____ _____

Pregnancy History: Total Pregnancies:_____Full term ____Pre-term ____Miscarriage ____Abortion ____Ectopic ____

Date of Birth	Length of pregnancy	Type of delivery	Sex	Weight	Living	Complications
_____	____weeks	Vaginal/C-Section	F/M	__lbs __oz	Y/N	_____
_____	____weeks	Vaginal/C-Section	F/M	__lbs __oz	Y/N	_____
_____	____weeks	Vaginal/C-Section	F/M	__lbs __oz	Y/N	_____
_____	____weeks	Vaginal/C-Section	F/M	__lbs __oz	Y/N	_____

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

GYN History:

At what age did you start having Menstrual periods? ____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

Have you ever had a sexually transmitted disease? Yes / No If yes, Type and Date(s):_____
Date of last Pap smear: _____ Normal/Abnormal? Have you had an abnormal Pap Smear? Yes / No
If yes, please give date(s) and explain:_____
Date of last Mammogram:_____ Have you ever had an abnormal mammogram? Yes / No
If yes, please give date(s) and explain: _____
Date of last bone Density test:_____ Normal / Osteopenia / Osteoporosis
Date of last Colonoscopy:_____Results:_____

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

How long have you been using your current form of birth control? _____
Are you planning to have another child ? _____My family is complete_____

Past Surgical History or any Hospitalizations:

Date:	**Procedure/Hospitalizations:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History **Please check if you currently have OR have had any of the following:**

____ ADHD
____ Abuse/Domestic violence
____ Anemia
____ Anesthesia complications
____ Anxiety Disorder
____ Arthritis/Rheumatoid/Osteo
____ Asthma
____ Bi-polar Disorder
____ Blood Clotting Disorder / DVT
____ Blood Transfusion
____ Breast Cancer
____ Breast Disease
____ Cancer
____ Cardiovascular Disease
____ Celiac Disease
____ Cerebrovascular accident/ Stroke
____ Colon Cancer
____ Depression
____ Dermatologic Disorder
____ Diabetes Mellitus
____ Endocrine Disorder
____ Endometriosis
____ Fibroids/Leiomyoma
____ Fibromyalgia
____ Gastrointestinal Disease
____ Genetic/ Hereditary Disorder
____ Genitourinary Disease
____ Gestational Diabetes
____ HIV/AIDS
____ Headaches/Migraines
____ Hematologic Disease
____ Hepatic/Liver Disease
____ Hypercholesterolemia(high cholesterol)
____ Hypertension
____ Hyperthyroidism
____ Hypothyroidism
____ IBS
____ Immunologic Disorder
____ Infertility
____ Multiple Sclerosis
____ Musculoskeletal Disease
____ Neurologic Disorder
____ Obesity
____ Osteoporosis
____ Ovarian Cancer
____ Polycystic Ovarian Disease (PCOS)
____ Pre-eclampsia
____ Psychiatric Illness
____ Pulmonary/Lung Disease
____ Renal/Kidney Disease
____ Seizures/Epilepsy
____ Substances Abuse/Dependence
____ Thrombophilias
____ Thyroid Disease
____ Urologic Disorder
____ Uterine Cancer
____ Varicosities
____ Vulvar Cancer
____ Other no listed:_____

☆**Is blood transfusion acceptable in case of an emergency? Yes/ No**
Do you have an Advance Directive? Yes / No

Immunizations:(Please list dates):Tetanus_____**HPV:**_____**Flu:** _____
COVID Vaccines:_____

Family History

YES / NO			YES / NO	
___	___	Breast Cancer	___	___ Diabetes
___	___	Ovarian Cancer	___	___ Thyroid Disorder
___	___	Uterine Cancer	___	___ Osteoporosis
___	___	Colon Cancer	___	___ Epilepsy / Seizures
___	___	Heart Disease	___	___ Strokes
___	___	Hypercholesterolemia	___	___ Depression / Bipolar / Schizophrenia
___	___	Hypertension	___	___ Birth Defects
___	___	DVT / Pulmonary Embolism	___	___ Other

If YES to any, please let us know your relation:

_____

_____

_____

_____

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 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