PHYSICIANS EAST, P.A.
Greenville Obstetrics and Gynecology
101 Bethesda Drive, Greenville, NC 27834

NAME:_____AGE: _____ MEDICAL RECORD #:_____

DATE: _____DOB:_____OCCUPATION:_____

Number of Pregnancies:_____ Number of Term Deliveries: _____ Number of Preterm Deliveries:_____

Number of Miscarriages:_____ Number of Elective Abortions:_____ Number of Living Children:_____

Date of Last Menstrual Period:_____ Primary Care Physician:_____

Please take a moment to fill this out so that we may update your medical history. Your confidential answers will help us to take better care of you.

Why are you coming to see us today?

_____
_____
_____
_____

What medical problems do you have?

_____
_____
_____
_____

What operations have you had?

Operation	Approx. year	Operation	Approx. year

What medications, vitamins or herbs do you take?

Name	Dose	Frequency	Name	Dose	Frequency

What medications are you allergic to?

PLEASE COMPLETE BACK PORTION ALSO

REVIEW OF SYSTEMS:

Do you have difficulty with depression?	Yes	No
Are you now in a relationship with a person who threatens or physically abuses you?	Yes	No
Do you have any problems or questions about sexual issues?	Yes	No
Do you have fainting spells or seizures?	Yes	No
Do you struggle with being short of breath?	Yes	No
Do you have chest pain or an unusual heart rate?	Yes	No
Do you have frequent nausea or vomiting?	Yes	No
Do you have frequent diarrhea or ever have bloody stools?	Yes	No
Have you had a recent change in abdominal size?	Yes	No
Do you have a problem with leaking urine?	Yes	No
Have you had a recent change in how frequently you must urinate, or does it hurt to urinate?	Yes	No
Have you had a significant change in weight or fatigue?	Yes	No
Do you have a problem with painful, swollen joints?	Yes	No
Have you had unusual fevers or chills?	Yes	No
Do you examine your own breasts?	Yes	No
Have you noted any breast lumps, skin changes, or nipple discharge?	Yes	No

SOCIAL HISTORY:

Marital Status (circle one) Single, Married, Divorced, Widowed
Do you smoke? Yes No
Do you drink alcohol? Yes No Frequency of consumption _____
Are you planning to get pregnant? Yes No
What, if anything, do you use to keep from getting pregnant? _____
Do you exercise regularly? Yes No
Do you take any vitamins? Yes No

FAMILY HISTORY:

Have any immediate family members had (please describe who):

Ovarian Cancer	Yes	No	_____
Other Cancer (specify)	Yes	No	_____
Heart Disease	Yes	No	_____
Diabetes	Yes	No	_____
Other medical problems (specify)	Yes	No	_____

Breast Cancer Risk Screen:
Race: White Black Asian Other: _____
Your age at first menstrual period?_____ Age at first live birth?_____
Do you have a mother/daughter/sister with Breast cancer?_____
Number of sisters/ daughters/ or mother with Breast cancer? _____
Number of previous breast biopsies? _____
Did biopsy have atypical hyperplasia? Yes No Unknown

HEALTH MAINTENANCE:
When was your last Pap smear?_____
When was your last mammogram? _____
When was your cholesterol last checked? _____
When was the last time you had a flexible sigmoidoscopy, if ever?_____
Have you ever had an abnormal pap smear and/or treatments/procedures for this? _____
_____
Have you ever been diagnosed or treated for a Sexually Transmitted disease?_____