ProHEALTH℠ Care

Suffolk Obstetrics & Gynecology

A Division of ProHEALTH Care Associates, LLP

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222 Middle Country Road, Smithtown, NY 11787 · Tel: (631) 361-7171

NAME: **DATE:**

PRIMARY CARE MD: **DATE OF BIRTH:** **AGE:**

RACE: **ETHINTICITY:** **DO YOU WANT A CHAPERONE PRESENT FOR YOUR EXAM:**

REASON FOR YOUR VISIT TODAY:

LAST MENSTRUAL PERIOD:	**AGE PERIOD BEGAN:**
LAST PAP TEST:	**PERODS ARE: REGULAR SOMEWHAT IRREGULAR VERY IRREGULAR**
LAST MAMMOGRAM:	**PERIOD INTERVAL:**
LAST BONE DENSITY TEST (DEXA):	**MENSTRUAL FOW LASTS HOW MANY DAYS:**
LAST COLONOSCOPY:	**ARE PERIODS PAINFUL: VERY SLIGHTLY NOT PAINFUL**
SURGERY:	**BLEEDING OR SPOTTING BETWEEN PERIODS: YES NO**
	HAVE YOU EVER MISSED A PERIOD WITHOUT BEING PREGNANT YES NO
ARE YOU SEXUALLY ACTIVE: YES NO	**DO YOU HAVE NEW OR MULTIPLE SEX PARTNERS: YES NO**
DO YOU HAVE ANY BLEEDING OR PAIN DURING INTERCOURSE: YES NO	**BIRTH CONTROL TYPE:**

HAVE YOU EVER HAD: HERPES CONDYLOMA (WARTS) CHLAMYDIA GONORRHEA SYPHILLIS TRICHOMONAS

PLACE OF LAST PAP: **WAS IT NORMAL: YES NO** **HAVE YOU EVER HAD AN ABNORMAL PAP: YES NO**

PREVIOUS OR CURRENT MEDICAL ILLNESSES: CHECK (√) ALL THAT APPLY ☐ NONE

☐ DIABETES	☐ THYROID DISEASE	☐ ARTHRITIS	☐ ASTHMA
☐ HIGH BLOOD PRESSURE	☐ LIVER PROBLEMS/HEPATITIS	☐ FRACTURES	☐ SEIZURES
☐ HIGH CHOLESTEROL	☐ BOWEL DISEASE	☐ OSTEOPOROSIS	☐ OTHER
☐ PHLEBITIS-CLOTS	☐ ULCERS-REFLUX DISEASE	☐ KIDNEY DISEASE	☐ CANCER, LIST TYPE
☐ HEART DISEASE ☐ VALVE DISEASE	☐ BLOOD DISEASE-ANEMIA	☐ DEPRESSION/ANXIETY	☐ LUNG DIEAE

SOCIAL HISTORY:	**FAMILY HISTORY**	**YES**	**RELATIVE/DETAILS**
TOBACCO USE: ☐ NO ☐ YES ________ CIG PER DAY	BREAST CANCER		
ALCOHOL USE : ☐ NO ☐ YES	OVARIAN CANCER		
DRUG USE: ☐ NO ☐ YES	COLON (BOWEL) CANCER		
REGULAR EXERCISE: ☐ NO ☐ YES	OTHER CANCER (PLEASE SPECIFY)		
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED	DIABETES		
PREVIOUS PREGNANCIES :	HEART DISEASE		
	HIGH BLOOD PRESSURE/STROKE		

#	DOB	Weeks of Preg	Hours in Labor	Vag or C-Sec	Sex	Birth Weight	Complications
1.							
2.							
3.							
4.							

Miscarriages or Abortions:

#	Month/YR	How Far Along	Cause	D & C	Complications
1					
2					
3					

SIGNATURE OF PATIENT:

DATE REVIEWED BY PROVIDER: **PROVIDER SIGNATURE:**

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Patient Name: ______________________________

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Medication List

Any Allergies:____

Are you taking over the counter medications, supplements, herbs, salves or ointments? If YES, please list all prescribed and over the counter medications, supplements, herbs, salves and ointments below.

Medication Name	Dose	Frequency	Method (Oral, Inj, etc.)	Date Started	Date Stopped

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Patient Name: ____Date: ______________

Circle All Symptoms that Apply

General Symptoms	Weight Loss, Weight Gain, Fever, Fatigue, Sleep Disturbances, Chills, Night Sweats
Breast Symptoms	Breast Pain, Masses/Lumps, Nipple Discharge
Gynecological (GU Symptoms)	Vaginal Discharge, Vaginal Itching or Burning, Painful Periods, Urinary Incontinence, Urinary Urgency, Pelvic Pain, Vaginal Dryness, Painful Intercourse, Lack of Desire, Abnormal Bleeding
Cardiovascular Symptoms	Shortness of Breath, Palpitations, Irregular Heart Beat, Chest Pain
Respiratory Symptoms	Asthma, Wheezing, Cough Blood, Chronic Cough
Gastrointestinal Symptoms	Nausea/Vomiting/Indigestion, Constipation, Chronic Diarrhea, Abdominal Pain
Hormonal (Endo Symptoms)	Hair Loss/Growth, Diabetes, Low Blood Sugar, Thyroid Problems, Hot Flashes/Sweats, Insomnia
Neurology Symptoms	Severe Memory Problems, Numbness/Tingling, Fainting, Seizures, Headaches, Dizzy
Psychological Symptoms	Anxiety, Depression, Frequent Crying, Mood Swings, Panic Attacks, PMS
Eye Symptoms	Visual Changes