Westlake GYN ---- Neeta Ambe- Crain , M.D. , FACOG

PATIENT MEDICAL DATA

Name____Age_____ DOB__________ S M D W Date______________

Preferred Name_____________________________ Cell phone #_________________________ Home# ________________________

Occupation___________________________ I give permission for messages on the private cell phone # Y_____ N ______

CIRCLE ALL THAT APPLY: Number of: Pregnancies ______ Deliveries ______ Miscarriages ______ Abortions ______ Ectopic _____

Date of last Menses: _______________ Cycle length: _________ Duration __________ Pain? Y N Heavy? Y N

#of Children _____ Ages: __________________ # of Vaginal Births _____ #of C-Sections ___

My last pap smear date: _____________ Normal ? Y N HPV? Y N mammogram date: _______________normal: Y___ N___

MEDICAL HISTORY (circle all that apply past or present):

Acne	Endometriosis	Heavy Bleeding	Infertility	Bone Loss-Osteoporosis	BrCA1+ BrCa2+
Anxiety	Depression	Epilepsy	Irritable Bowel	Pelvic Pain	Uterine Fibroids
Arthritis	Diabetes	Fibrocystic Breasts	Herpes	Kidney Stones	Stroke
Asthma	Cervical Dysplasia	Genital Warts	HPV	Migraines	Thyroid Problems
Blood Clots	Heart Disease	Hypertension	Obesity	Urinary Leakage	Herpes

Other Conditions or cancer history (list specific organ/stage/treatment): ____

____

SURGERY (list organs/ types of procedures/ year performed/minor gyn procedures/ovarian/uterine):____

____

ALLERGIES (circle below or list / specify reaction; rash, swelling, loss of breath):____

Penicillin Sulfa erythromycin Codeine Iodine tapes List any other allergies__________________________

____

MEDICATIONS (list names and doses of prescriptions, vitamins, herbal products, supplements):_______________________________________

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Tobacco use: _________Pack/day_______ Past/ Present Alcohol use : __________ Drug use:___________ IV Drugs_____________

FAMILY HISTORY (circle or list those only in your immediate family- parents/siblings):

Heart Disease/Stroke Osteoporosis Fibroids Cancer: Breast Colon Ovary Uterus Melanoma

Are you or have you ever been sexually active? Y N

Current Contraception (circle all that apply): Condoms OC Pills Diaphragm Depo-Provera Tubal

Abstinence IUD Withdrawal Vasectomy None N/A

Are you interested in a new form of contraception? Y___ N___ Maybe___ Do you want to get pregnant? Y___ N___