EvergreenHealth
OBSTETRICS & GYNECOLOGY CARE, TAN

Name_____ **Birthdate:**_____

Current Medication(s) Please list all medications and dosage ***Drug Allergies***
(A print out of medications currently listed in your chart is available upon request)

_____ _____

_____ _____

_____ _____

_____ _____

First day of your Last Period:_____ ***OR*** ***Age periods ended:***_____

Current Birth Control Method***:*** _____

Do you smoke? [ ] Yes [ ] No Have you smoked in the past? [ ] Yes [ ] No

>If yes, how many packs per day? _____ >If yes, for how long? _____ Year quit:_____

Please circle any symptoms you have now, or have recently experienced:

GENERAL: fevers, chills, sweats, loss of appetite, fatigue, malaise, weight loss

GENITOURINARY: vaginal discharge, incontinence, pain with urination, blood in the urine, urinary frequency, abnormal periods, pelvic pain, genital sores

CARDIVASCULAR: chest pain, palpitations, fainting, shortness of breath with exertion or lying down, swelling of the extremities

RESPIRATORY: cough, shortness of breath, productive cough, coughing up blood, wheezing

GASTROINTESTINAL: nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, blood in stool, jaundice

ENDOCRINE: intolerance to heat or cold, unusual thirst, hunger, urination, or unexplained weight change

BREAST: breast lump, nipple discharge, bloody nipple discharge, breast pain, breast enlargement, breast skin changes

MUSCULOSKELETAL: back pain, joint pain, joint swelling, muscle cramps, muscle weakness, arthritis

SKIN: rash, itching, dryness, suspicious lesions

NEUROLOGIC: paralysis, paresthesia, seizures, tremors, vertigo, fainting, frequent headaches

PSYCHIATRIC: depression, anxiety, memory loss, thoughts of suicide, hallucinations, paranoia

EYES: blurring, double vision, vision loss, sensitivity to light

EARS/NOSE/THROAT: earache, ear discharge, ringing, hearing loss, nasal congestion, nosebleeds, sore throat, hoarseness

ALLERGIC/IMMUNOLOGIC: hives, hay fever, persistent infections, HIV exposure

HEME/LYMPHATIC: abnormal bruising or bleeding, enlarged lymph nodes

_____ _____

Patient Signature Date