A Woman's Healing Center, LLC
COMPREHENSIVE CARE IN OBSTETRICS AND GYNOCOLOGY
Christine Skorberg, MD

I. Name_____ Today's Date _____

II. Reason for this visit_____

_____

I. PAST MEDICAL HISTORY

A. Have you ever had any of the following? If yes, please describe in the space provided.

		YES	DESCRIPTION
1.	Headaches	___	
2.	Thyroid Problems		___
3.	High blood pressure	___	
4.	Heart disease and/or stroke	___	
5.	Breast problems		___
6.	Hepatitis or other liver problems	___	
7.	Kidney or bladder problems		___
8.	Anemia		___
9.	Blood transfusion		___
10.	Diabetes	___	
11.	Cancer		___
12.	Seizure disorders		___
13.	Herpes		___
14.	Condylomata (warts)	___	
15.	Genetic or inherited diseases	___	
16.	Other medical problems		___

B. How old are your parents and how is their health? If deceased, what was the cause of death and age at death.

Mother _____

Father _____

C. Have any members of your family had any of the following? If yes, please describe in the space provided.

	YES	DESCRIPTION
1. High blood pressure/heart disease	___	
2. Diabetes	___	
3. Cancer	___	
4. Kidney disease	___	
5. Genetic or inherited diseases(s)	___	
6. other medical problems	___	

II. PLEASE ANSWER THE FOLLOWING QUESTIONS AND PROVIDE SPECIFIC INFORMATION WHEN APPROPRIATE. If A QUESTION DOES NOT APPLY, SKIP IT AND GO ON TO THE NEXT ONE.

A. Menstruation:

2. How old were you when you had your first period? _____
3. What was the date of your last menstrual period? _____
4. Was your last menstrual period normal? _____
5. How many days pass between the first day of each period? _____
6. How long do your periods last? _____
7. On the heaviest day(s), how many pads and/or tampons do you use?

   _____

8. Do you have cramps with your periods? _____

   If yes, a) When do they start in relation to bleeding?

   _____

   b) How long do they last? _____

   c) Is the pain generally mild____ moderate____ severe ____

   d) Is the pain getting worse? _____

   e) How do you treat your pain? _____

9. What do you use for birth control? _____
10. Have you ever had complications with any type of birth control? _____

    If yes, what was it? _____

11. Have you ever had any difficulty becoming pregnant? _____
12. Are you past your menopause or have you had a hysterectomy? _____

    If yes, have you noticed any vaginal bleeding since? _____

III. GYNECOLOGY

13. Do you examine your breasts? _____
14. Have you ever had a mammogram? _____

    If so, when and what were the results? _____

15. Have you ever noticed any lumps in your breast? _____

    If so, what was done? _____

16. Have you ever had any discharge from your breasts? _____
17. Have you ever had any pain or discomfort with intercourse? _____
18. Have you had problems with frequent or recurrent bladder or kidney infection? _____
19. Have you had frequent and/or recurrent vaginal infections? _____
20. Have you ever had infections in your tubes and/or ovaries? _____

21.When was your last pap smear?_____

22. Have you ever had an abnormal pap smear? _____

If yes, when and what was done? _____

IV. OTHER MEDICAL HISTORY INFORMATION

23.Are you allergic to any medication? _____

If so, what is the name of the medication and what happened when you took it? _____

24.Do you take any over the counter or prescription medication?

If so, please list the name, dosage, and how long you have taken it.

NAME	DOSAGE	DURATION TAKEN

25.Do you smoke? _____ If yes, how many cigarettes per day? _____

And how long have you smoked? _____

26.How many alcoholic beverages do you have in one week? _____

27.Do you use other recreational or social drugs? _____

28.Do you have a history of any of the following conditions?

a) Severe, recurrent headaches _____

b) Fainting episodes _____

c) Recurrent shortness of breath _____

d) Edema (swelling) of hands or ankles _____

e) Chronic cough _____

f) Have you ever coughed up blood? _____

g) Have you ever noticed heavy chest pain with exercise? _____

h) Have you noticed that your heart rate is beating irregularly or rapidly? _____

i) Do you have lower abdominal cramps/pain not associated with your menstrual periods? _____

V. HOSPITALIZATIONS

Please list any operations or serious illnesses that required hospitalization (do not include pregnancies)

MONTH AND YEAR	ILLNESS/OPERATION	HOSPITAL
1.		
2.		
3.		

4.

5.

VI. OBSTETRIC/PREGNANCY HISTORY

29. How many times have you been pregnant? _____

30. How many living children do you have? _____

31. Have you ever had a miscarriage? _____

If so, when? _____

32. Have you ever had an abortion? _____

If so, when? _____

33. Have you ever had a premature birth? _____

If so, when was it and please explain the details _____

_____

6. PLEASE RECORD THE DETAILS OF YOUR PREGNANCIES

DATE OF BIRTH	SEX	WEIGHT	LENGTH OF GESTATION	CHILD'S NAME	DELIV TYPE & ANESTHESIA	WHERE DELIV TOOK PLACE

Did you have complications with any of your pregnancies? If so, what? _____

_____

_____

_____

_____

IX. ARE THERE ANY POINTS IN YOUR PAST HISTORY OR OTHER QUESTIONS YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR? IF SO, PLEASE DESCRIBE.

_____

_____

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