Name: _____ Visit Date: _____

Please complete questions below before your appointment.
Thank you—Berkshire OB/GYN Associates, Inc.

Visit background:

1. Who is your primary care doctor (PCP, internist)? _____
2. Emergency contact: _____
3. Telephone number: _____
4. What would you like to discuss at today's visit? _____

History:

1. Have you ever been hospitalized? If yes, for what? _____
2. Do you have any of the following medical problems? Have you had them in the past? Please mark with an "X"

□ Asthma	□ Lung disease	□ HIV/AIDS	□ Heart disease	□ Diabetes
□ Hypertension	□ Stroke	□ Blood clot	□ Lupus	□ Chickenpox
□ Cancer	□ Reflux/Ulcer	□ Depression	□ Anemia	□ Transfusion
□ Gallbladder disease	□ Glaucoma	□ Arthritis	□ Hepatitis	□ Thyroid disease
	□ Migraines	□ Bleeding or clotting disorders	□ Seizures	
□ DES exposure	□ Kidney stones		□ Other:	

3. Please list surgeries you have had: _____
4. Please list your medications (and dosages) including vitamins and herbals: _____
5. How many times have you been pregnant? _____
6. How many children do you have? _____
7. List your mother's health problems: _____
8. List your father's health problems: _____
9. List any other family health problems: _____
10. Do you smoke cigarettes? _____
11. If you smoke, would you like materials/help to quit? _____

Review of Systems:

Please place an "X" next to any item that currently applies to you:

1. Constitutional	□ no problems □ unexplained weight loss □ frequent fevers □ constant fatigue □ other:
2. Eyes	□ no problems □ vision changes □ glasses/contacts □ blindness □ seeing spots/blurred vision □ other:

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3. Ear, Nose, Throat, Head	□ no problems □ frequent headaches □ hearing loss □ sinusitis □ tooth decay □ other:
4. Cardiovascular	□ no problems □ difficulty breathing when walking □ chest pain □ palpitations □ rapid heart beat □ other:
5. Respiratory	□ no problems □ wheezing □ chronic cough □ coughing up blood □ constant difficulty breathing □ other:
6. Gastrointestinal	□ no problems □ frequent diarrhea □ frequent constipation □ pain □ blood in stool □ nausea and vomiting □ indigestion □ heartburn □ incontinence of stool or gas □ other:
7. Genitourinary	□ no problems □ blood in urine □ burning with urination □ PMS □ painful periods □ leaking urine □ frequent urination □ unusual vaginal discharge □ pain with sex □ irregular bleeding □ pelvic pain □ other:
8. Musculoskeletal	□ no problems □ joint pain □ low back pain □ other:
9a. Skin	□ no problems □ rashes □ new or changing moles □ other:
9b. Breast	□ no problems □ lump, mass, or nodule □ nipple discharge □ breast pain with periods □ breast pain unrelated to periods
10. Neurologic	□ no problems □ seizures □ severe memory problems □ falls □ other:
11. Psychiatric	□ no problems □ frequent depressed moods □ severe anxiety □ insomnia □ excessive sleeping □ other:
12. Endocrine	□ no problems □ tremors □ excessive thirst & urination □ sweats □ bulging eyes □ heat/cold intolerance □ other:
13. Hematologic/ Lymphatic	□ no problems □ frequent, easy bruising □ excessive bleeding □ swollen lymph nodes □ other:
14. Allergic	□ food allergies: □ seasonal allergies □ drug allergies: □ latex allergy

Notes:

_____

_____

Other:

When was the first day of your last menstrual period?

Do you have any other concerns/questions for today?

Would you like a prescription for emergency contraception?

Patient Signature: _____

Reviewed by: _____

Date: _____