GEORGETOWN OB-GYN

John Sherman, MD | Vincent Sherman, MD | Kelly Montiville, MD | Sara Cooper, MD

Date: __________________

Patient Name:____ **DOB:** _____________________________ **Age:**_________________

Reason for your visit today: ____

How did you hear about us?: ____

First day of last period:________________ **Do you have regular monthly periods?** Y / N

How often do your periods come? _____________ **Age at first period:** _____________

Periods are: Mild Moderate Heavy **Cramps are:** Mild Moderate Severe

Drug Allergies & Reaction: ____

Do you want to get pregnant?
What are you using to prevent pregnancy?____

Age at first intercourse: ______ **Number of partners (lifetime):** _______

How long have you been with your current sexual partner? ____

Are you having any libido changes? Y / N (please explain) ____

Do you have pain with intercourse? Y / N (please explain) ____

Sexual Preference: (please circle) Heterosexual Homosexual Bisexual

Have you had a new sexual partner since last exam? Y / N **Do you desire testing for STDs?** Y / N

Have you ever had a sexually transmitted disease? Y / N (**c**ircle any that apply)

Gonorrhea Chlamydia Herpes Hepatitis B HIV Syphilis Genital Warts PID Trichomonas HPV

Do you use tobacco products? Y / N **About** ____________ **cigarettes per day**

Do you drink alcohol? Y / N **About** _____________**drinks per week**

Do you use recreational drugs? Y/N **What kind?** ______________________

Are you experiencing any vaginal or urinary:

Discharge Odor Burning Itching Frequency Urgency Loss of Urine

Other concerns: ____

Last Pap smear: ____________ **Results** ____

Have you ever had an abnormal pap smear? Y / N

If yes, please give year and any procedures ____

Have you received the HPV vaccine course? Y / N / incomplete course

Last Mammogram: ____________ **Results** ____

Have you ever had an abnormal mammogram? Y / N

If yes, please give year and any procedures ____

Do you do monthly breast exams? Y / N / Occasionally

Are you in a relationship with someone who physically, verbally, or emotionally abuses you? Y / N

Do you have a history of sexual assault or abuse? Y / N

Do you diet? Y / N **What type**? ____

Do you exercise? Y / N **How often & how long?** ____________________________________

Notes: ____

Please list all surgeries/hospitalizations:

	Date:

Please list all pregnancies:

Date	Outcome/Method of delivery	Gestational age	Sex	Weight	Complications

Please list all medications and supplements:

Please indicate if you are having any current problems in the following areas by marking an X in the appropriate column.

General wellness	Y ______	N _______	Muscle/joints/bones	Y ______	N _______
Eyes	Y ______	N _______	Skin	Y ______	N _______
Ear, nose, throat	Y ______	N _______	Neurological	Y ______	N _______
Heart / circulation	Y ______	N _______	Psychiatric	Y ______	N _______
Lungs / breathing	Y ______	N _______	Endocrine	Y ______	N _______
Stomach / digestion	Y ______	N _______	Blood / lymph	Y ______	N _______
Reproduction/ urinary	Y ______	N _______	Allergies	Y ______	N _______

Disease	Self	Mother	Father	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Brother/ Sister	Other
Alcoholism									
Anemia									
Arthritis									
Lung disease									
Blood clots									
Diabetes									
Heart disease									
High cholesterol									
High blood pressure									
Kidney disease									
Liver disease									
Mental illness									
Osteoporosis									
Seizures									
Stroke									
Thyroid disease									
Colon Cancer									
Breast Cancer									
Uterine Cancer									
Ovarian Cancer									