HIGHLAND CLINIC

PATIENT HISTORY FORM

DATE: _______________ The Women's Clinic **GYN VISIT** PCP/REFERRING MD ____________________

Provider you are seeing today (please circle)
☐ Dr. Burlison ☐ Ashli Davis ☐ Dr. Popwell ☐ Dr. Robinson ☐ Dr. Tynes ☐ Dr. Scotto ☐ Brooke Stokes

Name:____**DOB**:_________________________**Age**:_________

Reason for Visit: ANNUAL **Problems:** ☐ Vaginal discharge ☐ Bleeding ☐ Abnormal Pap
☐ Other_____________________________

Menstrual History Last Menstrual Period:_____________ Form of Birth Control _______________________

Pregnancy History # of Full Term_____# of Premature____# of Live Birth(s)_____
# of Ectopic____# of Miscarriage(s)____ # of Elective Abortion(s)____Currently Pregnant ☐ No ☐ Yes

Menopause Year / Age ___________

Date of Last - Pap:__________Mammogram:__________Colonoscopy:__________ Dexa/Bone scan:__________

Medications: *Drug Name Dose/Strength How you take it (for example, once a day, twice a day, etc)* ☐ None

____ ____
____ ____
____ ____
____ ____

***__Allergies:__ ☐ NONE or list each allergy____

Review of Systems: ***Do you have?***

☐ Breast Tenderness ☐ Urgency to Urinate ☐ Abdominal Pain ☐ Painful Menstruation (dysmenorrhea)
☐ Breast Mass ☐ Bloody Urine ☐ Changes in Bowel Habits
☐ Nipple Discharge ☐ Incontinence ☐ Vaginal discharge
☐ Painful Urination ☐ Nausea ☐ Abnormal bleeding
☐ Frequent Urination ☐ Vomiting ☐ Painful Sexual Intercourse (dysparunia)

Past Medical / Family History: (list family member)

☐ No changes since last visit

	Self	Fam		Self	Fam
Diabetes	_____	__________	Varicosities/Phlebitis	____	____________
Hypertension	_____	__________	Thyroid Disease	____	____________
Heart Disease	_____	__________	GI Disease	____	____________
Anemia	_____	__________	Blood Transfusion	____	____________
Kidney Disease	_____	__________	Pulmonary (asthma)	____	____________
Neuro / Epilepsy	_____	__________	Breast Disease	____	____________
Psychiatric Dz	_____	__________	Cancer	____	____________
Other____________________________			Hepatitis/Liver Dz	____	____________

Past Surgical History (list all surgeries)____

Social History:

Tobacco ☐ current ☐ former ☐ never Type / Amount__________________
Alcohol Use ☐ Yes ☐ No drinks/wk_________________
Drugs ☐ Yes ☐ No Specify__________________

Infection History

Hx of STD ☐ Yes ☐ No
Herpes ☐ Yes ☐ No
HIV ☐ Yes ☐ No
Hep B ☐ Yes ☐ No