



PATIENT CHART INFORMATION ♦ Please complete & bring to your first appointment.

Patient *LEGAL* Name: _____

Referring Physician: _____
Address: _____

Phone (Incl. Area Code): HOME: _____; WORK: _____; CELL: _____

E-mail address:

► IF YOU ARE NOT CERTAIN OF AN ANSWER PUT A QUESTION MARK ◀

Main reason for seeking medical attention: Consultation Second Opinion Problem
 Well woman care (desire GYN health check-up & Pap smear)

Describe in detail the reason or problem that brings you to our office:

SOCIAL HISTORY

Age: _____ Birth Date: _____ Height: _____ Weight: _____

Marital Status: Single Married Divorced Separated Domestic Partnership

Married more than once? No Yes, & dates married: _____

Length of time that you have lived in the Portland area: _____ Months Years

EDUCATION: _____ years of High School _____ years of College _____ years of Graduate School

OCCUPATION: _____ RELIGION: _____

Do you smoke? No Yes, & the number of cigarettes packs per day is _____

Do you use alcohol? No Yes, & the amount that I consume is _____ drinks daily weekly monthly

Do you use any street drugs or marijuana, etc.? Yes No

HUSBAND/PARTNER'S Name: _____ Age: _____ Birth Date: _____

HUSBAND/PARTNER'S Education: _____ years of High School _____ years of College _____ years of Graduate School

HUSBAND/PARTNER'S Current Health Status: Excellent Good Fair Poor

HUSBAND/PARTNER'S Height: _____, Weight: _____ & Occupation: _____

LIFESTYLE HISTORY

Do you exercise? No Yes, & the kind of exercise that I do is:

_____ How often? _____

Caffeine intake? Amount per day _____

Hobbies, Sports, Activities: _____

MENSTRUAL HISTORY

Age of first menses? _____ Date of last menses? _____ Cycle length: _____ Flow days: _____

Any abnormalities, changes or spotting? _____

Painful menses? Yes No Date of last Pap smear: _____ Abnormal Pap smears? Yes No

Painful intercourse? Yes No Pelvic pain? Yes No Incontinence? Yes No

Lubricants? Yes No Douching? Yes No Any sexually transmitted diseases? _____

OBSTETRIC HISTORY

- ▶ Number of pregnancies: _____
- ▶ Number of babies born alive: _____
- ▶ Number of stillbirths: _____
- ▶ Number of Premature babies (less than 5½-lbs. or earlier than 37-wks.) born alive: _____
- ▶ Number of Cesarean Sections: _____
- ▶ 3 or more first-trimester Miscarriages No Yes
- ▶ Number of Therapeutic abortions: _____
- ▶ Any serious physical complications with any pregnancy, labor or delivery? No Yes (please explain):

▶ How many living children do you have? _____

Name:

Birth Date:

Male/Female:

▶ Were any of your children born with congenital or developmental problems? No Yes, & (please comment):

▶ Did you ever have any serious problems during pregnancy, labor & delivery, or the postpartum period (up to the fourth week following discharge from the hospital), e.g., severe nausea & vomiting during pregnancy, depression during or after pregnancy? No Yes

GENERAL HEALTH		
√mark any of the following symptoms that you have NOW or that have been present during the PAST 6-MONTHS		
<input type="checkbox"/> Any eye problem, injury, impaired sight, dryness <input type="checkbox"/> Bloody sputum <input type="checkbox"/> Swelling of hands, feet, ankles <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Black or tarry stool <input type="checkbox"/> Joint pain or stiffness <input type="checkbox"/> Loss of consciousness, fainting or seizures <input type="checkbox"/> Depression <input type="checkbox"/> Hot flashes <input type="checkbox"/> Salt craving <input type="checkbox"/> Bladder or kidney infection/stones <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Disinterest or displeasure with daily activities	<input type="checkbox"/> Any ear disease, injury, impaired hearing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Acne <input type="checkbox"/> Difficulty in swallowing <input type="checkbox"/> Constipation <input type="checkbox"/> Abdominal cramps or pain <input type="checkbox"/> Leg cramps or limp <input type="checkbox"/> Nightmares or insomnia <input type="checkbox"/> Marriage problems <input type="checkbox"/> Abnormal thirst <input type="checkbox"/> Excessive tiredness or weakness <input type="checkbox"/> Blood in urine <input type="checkbox"/> Problems with anger <input type="checkbox"/> Thoughts of suicide or death	<input type="checkbox"/> Chronic or frequent cough <input type="checkbox"/> Rapid or irregular breathing <input type="checkbox"/> Recent weight loss/gain <input type="checkbox"/> Heartburn or indigestion <input type="checkbox"/> Blood or mucus in stool <input type="checkbox"/> Back pain <input type="checkbox"/> Severe headaches (migraines) <input type="checkbox"/> Worry, tension or nervousness <input type="checkbox"/> Unusual growth or loss of hair <input type="checkbox"/> Tremor or numbness in hands or feet <input type="checkbox"/> Breast discharge or change in size (aside from breast-feeding) <input type="checkbox"/> Skin sores, rash or itching; lumps in breast or groin <input type="checkbox"/> Loss of sexual interest <input type="checkbox"/>

Have you ever been hospitalized for any medical/surgical illness? No Yes, and diagnosis and year:

Have you ever been hospitalized for any psychiatric illness? No Yes, and diagnosis and year:

Do YOU or your PARTNER have the following ancestry?	YOU		PARTNER		FOR CLINIC USE:	
	No	Yes	No	Yes	IF YES	IF POSITIVE
Southeast Asia, Taiwan, China, Philippines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CBC with MCV	Test Partner
Italy, Greece, or the Middle East	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CBC with MCV	
Eastern European (Ashkenazi) Jewish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ashkenazi Jewish Panel	
French Canadian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tay-Sachs biochem.	
Cajun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tay-Sachs biochem.	
African American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hgb electrophoresis	

FOR CLINIC USE: Offer Cystic Fibrosis testing

Has a <i>parent, sibling, grandparent, aunt, uncle, first-cousin</i> in either of your families had:	YOUR Family		PARTNER'S Family		FOR CLINIC USE:
	No	Yes	No	Yes	IF YES
Down syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Translocation? Offer consult.
Any chromosome abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neural tube defects, e.g., open spine, spina bifida, anencephaly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Folate 4 mg qd
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If maternal side, offer consult.
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CF testing
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hgb electrophoresis
Thalassemia (Mediterranean anemia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tay-Sachs disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tay-Sachs testing
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Offer consult
Fragile X syndrome (<i>X-linked disorder – screening based on maternal history/condition</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fragile X testing
Muscular Dystrophy (<i>X-linked disorder – screening based on maternal history/condition</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Offer consult
Neurofibromatosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Huntington disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Phenylketonuria (PKU) or any other metabolic condition requiring special foods or other treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Deafness or hearing loss beginning in childhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Known genetic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If syndromic, e.g., associated with other malformation or mental retardation, offer consult.
Heart defect (from birth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cleft lip and/or cleft palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Limb birth defects (extra/missing digits, malformed arms, legs, hands, feet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Any other birth defects (missing kidney, water on the brain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

FOR CLINIC USE:

Patient offered Genetics consult? No Yes Patient declined: _____
(Patient's Signature)

FAMILY HISTORY				
Family Member	Living		Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				
Brother or Sister: 1.				
2.				
3.				
4.				
5.				
Son or Daughter: 1.				
2.				
3.				
4.				
5.				
DO YOU HAVE ANY BLOOD RELATIVES WHO HAVE HAD:				
	√	Who?	√	Who?
Diabetes	<input type="checkbox"/>		Glaucoma	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>		Alcoholism	<input type="checkbox"/>
Cancer	<input type="checkbox"/>		Emotional disorders	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>		Depression	<input type="checkbox"/>
Other	<input type="checkbox"/>			

MEDICATIONS	Never	Not in past year	Occasionally	Frequently	Daily
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone or steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diuretic (water) pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizer or nerve pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite suppressant or pep pill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hormone pill or shots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping pill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infertility drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LIST ALL CURRENTLY USED PRESCRIPTIONS & OVER-THE-COUNTER MEDICATIONS & THEIR DOSAGES	
Yourself	Husband/Partner

Are you now in poor health or suffering from any chronic pain?

(None) (Moderate) (Severe)
PAIN SCALE (circle): 0 1 2 3 4 5 6 7 8 9 10

Average weight in the past year? _____ Weight at age 18? _____ Maximum weight (non-pregnant)? _____

Do you have any allergies (side-effects) to drugs, vaccines, or other agents (e.g., aspirin or pain medication, penicillin, sulfa, Novocain, birth control pills, Other: _____)? No If yes, please describe:

ABUSE ASSESSMENT SCREEN	Yes	No
Have you ever been emotionally or physically abused by your partner or someone important to you?	<input type="checkbox"/>	<input type="checkbox"/>
Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? ► If “yes”, by whom? <input type="checkbox"/> Husband <input type="checkbox"/> Ex-husband <input type="checkbox"/> Partner <input type="checkbox"/> Stranger <input type="checkbox"/> Other <input type="checkbox"/> Multiple ► Number of times?	<input type="checkbox"/>	<input type="checkbox"/>
Within the past year, has anyone forced you to have sexual activities? ► If “yes”, by whom? <input type="checkbox"/> Husband <input type="checkbox"/> Ex-husband <input type="checkbox"/> Partner <input type="checkbox"/> Stranger <input type="checkbox"/> Other <input type="checkbox"/> Multiple ► Number of times?	<input type="checkbox"/>	<input type="checkbox"/>
Are you afraid of your husband or anyone else that you have ✓marked above?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like a referral for counseling?	<input type="checkbox"/>	<input type="checkbox"/>

THANK YOU FOR YOUR ASSISTANCE