Grandview Gynecology and Obstetrics

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Form G-1
A. 200325

Patient History

General Obstetrics/Gynecology Visit

Demographic Information

Surname	Given names		Date of birth YYYY - MM - DD	Age	Today's date YYYY - MM - DD
Personal Health Number	Home phone ( ) -	Cell phone ( ) -	Work phone ( ) -	Preferred contact number	
Address		Email		Receive office email newsletter? ☐ Yes	
Reason for your visit today		Treatments you've tried for this problem			
Preferred appointment reminder method		Name of GP/family doctor	Referring doctor (if different)		

Obstetric History

How many times have you been pregnant?	Number of miscarriages	Number of abortions	
Number of ectopic pregnancies	Complications during pregnancy	If pregnant, due date	
Birth years and types (vaginal, cesarean) of children		Do you have plans for future fertility?	
		If trying to conceive, how long trying	

Gynecologic History

Are you currently sexually active? ☐ **Yes** ☐ **No** ☐ **Never have been**	Who do you have sex with? ☐ **Men** ☐ **Women** ☐ **Both**	Current contraception		
Have you had any STIs? (list)	Do you have pain with sex? ☐ **Always** ☐ **Sometimes** ☐ **Never**	Have you ever been physically or sexually harmed? ☐ Yes		
First day of last menstrual period/year of menopause		Do you get a monthly period? ☐ **Yes** ☐ **No**	Are periods painful? ☐ **Yes** ☐ **No**	
Rate of flow ☐ **Heavy** ☐ **Medium** ☐ **Light**	Days of flow	Any menopausal symptoms? (hot flashes, vaginal dryness, etc.)		
Date of last Pap YYYY - MM - DD	Any abnormal Paps in the past? ☐ Yes	Prior gynecologic history (hormone therapy, D&Cs, biopsies, etc.)		

Social History

Marital status	Occupation

General Medical History

Current or previous medical conditions

☐ **Heart attack or stroke** ☐ **High blood pressure** ☐ **Blood clotting disorder** ☐ **Lung disease**
☐ **Liver issues** ☐ **Kidney issues** ☐ **Bladder problems** ☐ **Bowel problems** ☐ **Thyroid issues**
☐ **Depression** ☐ **Anxiety** ☐ **Addiction** ☐ **Migraines** ☐ **Diabetes** ☐ **Cancer:** _____
☐ **Other conditions:** _____

Current medications (include doses)	Surgical history (include year, anesthetic problems)
Preferred pharmacy (include name and location)	**Allergies (any type)**

Medical problems or cancers in family

Height	Weight	Date of last mammogram YYYY - MM - DD	Date of last colonoscopy YYYY - MM - DD	Abnormal screening result in past? ☐ Yes

Alcoholic drinks per week	Cigarettes per day	Other drug use

Office Policies

Welcome to our office. We are pleased to be a part of your health care team.

Please advise our medical office assistants if you have had any **lab work, ultrasounds, x-rays,** or any other tests relevant to your visit today.

Appointment time with a specialist is very valuable. For the specialists in our office, we schedule 30 minutes for a consultation with our new patients and 15 minutes for a follow-up appointment.

We appreciate that schedules change and ask for as much notice as possible if you need to reschedule your appointment with us. Missed appointments delay care for all patients. Late cancellations and missed appointments may be assessed a fee if we are given less than **2 business days notice**. This fee is **$100** for a consultation appointment and **$40** for a follow-up appointment.

Please keep your contact information current because it makes it easy for us to contact you in the event of unexpected schedule changes. We are often called to the hospital for emergencies. This is not within our control. If such an event should occur, our staff will do their best to reach you and provide you with the soonest appointment possible — often within the same day.

Thank you for allowing us to be a part of your health care team. We look forward to working with you towards ongoing health and wellness.

Please sign below to indicate that you have read and understood this information, and to certify that the information you have provided on this form is true, accurate and complete.

Patient signature	Print name	Date YYYY - MM - DD

If you helped someone prepare this form (parent, translator, etc.), please enter your information below.

Preparer name	Relationship to patient