Jasmin Ghuznavi, MD, FACOG Kulsoom Jafri, MD Heather Powers, FNP

Name: ______________________________ Date of Birth: ____________________ Today's Date: _________

Medical History (any new from last visit):

☐ Asthma	☐ Depression/Mental Illness	☐ Diabetes: **Type 1**
☐ Arthritis	☐ High Blood Pressure	☐ Diabetes: **Type 2**
☐ Heart Murmur	☐ HIV	☐ Polycystic Ovaries (PCOS)
☐ Heart Disease	☐ Kidney Disease	☐ Endometriosis
☐ Stroke	☐ Osteoporosis	☐ Uterine Fibroids
☐ Epilepsy	☐ Cholesterol	☐ Cancer (Please specify type)
☐ Migraines	☐ Thyroid Disease: **Hyperthyroid**	☐ ______________________
☐ Lupus	☐ Thyroid Disease: **Hypothyroid**	☐ Other:
☐ Emphysema	☐ Ovarian Cysts	____________________

Social History: (please circle) Single Married Divorced Widowed Female Partner Male Partner

Occupation: ____________________________________ Student: Yes No

Do you use tobacco? Yes No Previously How many packs/cigarettes per day?____________________________

Do you use alcohol? Yes No Previously How many drinks per day/week?____________________________

Do you use drugs? Yes No Previously What kind?___________ How Often?________________________

OB/GYN History:

First day of your last period:____________________________

Age of first period:______ How Long do your periods last?_______ How many days between periods?______

Cramping during periods? Yes No Flow: Heavy Medium Light Clots: Yes No

Are you currently sexually active?...Yes No

Is your current sexual partner(s)?..Male Female Both

Do you have a history of sexually transmitted diseases? Yes No Please specify type:________________

What do you currently use for contraception?____

What have you previously used? IUD Pills Condoms Patch Nuvaring Other:_______

Date of last pap smear:______ Normal Abnormal Date of last mammogram:_______ Normal Abnormal

Date of last colonoscopy:_______ Normal Abnormal Date of last bone density:______ Normal Abnormal

How many times have you been pregnant?___________ Number of children?____________________________

Date of delivery	Weeks at delivery	C-section/ vaginal	Male/Female	Baby's birth weight	Complications

Name: ____

Surgical History (any new from last visit)

Date	Type of surgery	Date	Type of surgery
________	______________________	________	______________________
________	______________________	________	______________________
________	______________________	________	______________________

Medication (please include vitamins and over the counter medications):

Medication	Dosage (mg, IU)	How often do you take it
______________________	__________________	__________________
______________________	__________________	__________________
______________________	__________________	__________________
______________________	__________________	__________________
______________________	__________________	__________________
______________________	__________________	__________________
______________________	__________________	__________________

Allergies (please include medications, environmental, and food allergies):

Allergy	Reaction (hives, swelling, etc)	Allergy	Reaction
______________	______________	______________	______________
______________	______________	______________	______________

Family Medical History (please include relationship to you, i.e. parents, siblings, grandparents):

- ☐ Diabetes: **Type 1**__________________
- ☐ Diabetes: **Type 2**__________________
- ☐ High Blood Pressure________________
- ☐ Depression/Mental Illness___________
- ☐ Thyroid Disease: **Hypothyroid**______
- ☐ Thyroid Disease: **Hyperthyroid**_____
- ☐ Kidney Disease___________________
- ☐ Osteoporosis_________________
- ☐ Stroke_______________________
- ☐ Lupus_______________________
- ☐ Heart Disease_________________
- ☐ Emphysema__________________
- ☐ Breast Cancer_________________
- ☐ Colon Cancer_________________
- ☐ Ovarian Cancer
- ☐ Other Cancer (please specify)
  ____
  ____
- ☐ Other (please specify)
  ____
  ____

Review of Symptoms (Please include any symptoms or problems you are experiencing today):

Concerns of problems you would like to discuss today:____

- ☐ Tired/Fatigue
- ☐ Loss of appetite
- ☐ Bleeding from gums
- ☐ Headache
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Shortness of breath with exercise
- ☐ Nausea
- ☐ Frequent urination at night
- ☐ Urinary frequency
- ☐ Urinary urgency
- ☐ Blood in urine
- ☐ Joint Pain
- ☐ Loss of hair
- ☐ Memory/concentration difficulty
- ☐ Decreased libido (sex drive)
- ☐ Ringing in ears
- ☐ Vomiting
- ☐ Blood in stool
- ☐ Intolerance to cold
- ☐ Intolerance to heat
- ☐ Night sweats
- ☐ Decreased hearing
- ☐ Diarrhea
- ☐ Incontinence
- ☐ Anxiety
- ☐ Difficulty sleeping
- ☐ Weight loss
- ☐ Weight gain
- ☐ Lightheadedness
- ☐ Breast lump
- ☐ Breast tenderness
- ☐ Nipple discharge
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Heartburn