

Today's Visit
 Date _____ Reason _____ Referred By _____

Demographics
 Name _____ Birthday _____ Age _____ Social Sec. # _____ Marital Status _____
 Address _____ City _____ State/Zip _____
 Phones: Home _____ Work _____ Emergency: Contact _____
 Cell _____ Parent _____ Phone _____

RX
 Pharmacy _____ Location (Street / City) _____

Financial Insurance
 Employer _____ Name _____
 Type of Work _____ Employer _____
 Insurance _____ Company _____ Contract # _____
 Date of Birth _____ Date of Birth _____

Total Number of Pregnancies: _____ Total Number of Living Children _____ Miscarriages: _____

Name of Child	(Sex)	Health	Year Born & Weight	M.D./CNM	Hospital
_____	()	_____	_____	_____	_____
_____	()	_____	_____	_____	_____
_____	()	_____	_____	_____	_____
_____	()	_____	_____	_____	_____

Menstrual History
 Last Period _____ Cycle Length _____ Days Flow: Regular / Irregular
 Cramps? No Yes How severe? _____ Amount of flow: Light Medium Heavy Clots
 Pain Medication No Yes, name of medication _____ When? Before / During / After bleed
 Menopause No Yes **Birth Control:** _____

Cancer Osteo Screening
 Self Breast Exam _____ Last Pap Date _____ Last Dexa Date _____
 Last Mammogram Date _____

Illness/Surgery Excluding Childhood
 Year: _____ Type of Illness or Surgery: _____ Hospital: _____ M.D.: _____

Allergies
 Known Drug Allergies? No Yes, if so, which ones _____
 Known Latex Allergy? No Yes Don't Know

Medications O-T-C Drugs Special Health Foods

Name	Dose/Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Date _____ By _____ Comment _____

Family History

Mother, Father, Grandparents, Brothers/Sisters, Children

Who _____ Disease _____ Status _____

Such as diabetes, heart condition, cancer, high blood pressure, etc.

Social History

Marital Status _____ Smoking No Yes, if so: Packs/day _____ # Years _____
 Type of work done _____ Alcohol No Yes, if so: Drinks/day _____ Drinks/Wk _____
 Use seat belt Yes No Street Drugs No Yes, if so: Type _____
 Regular Exercise Yes No Frequency _____

Have you had any of these problems? Answer each item with a Yes (Y) or a No (N)

Review of Systems

<p>Constitutional</p> <p>Y N Fatigue Y N Weight Change Y N Fever/Chills other: _____</p>	<p>Neurological</p> <p>Y N Tremors Y N Dizziness Y N Numbness/Tingling other: _____</p>	<p>Psychiatric</p> <p>Y N Moody Y N Depressed Y N Considered Suicide other: _____</p>	<p>Eyes</p> <p>Y N Blurred Vision Y N Pain other: _____</p>
<p>Ears, Nose, Throat, Mouth</p> <p>Y N Ear Infection Y N Hearing Problem Y N Sinus Y N Sore Throat other: _____</p>	<p>Hematologic/Lympatic</p> <p>Y N Swollen Glands Y N Bleeding Problems other: _____</p>	<p>Endocrine</p> <p>Y N Appetite Change Y N Excessive Thirst Y N Fatigue/Sluggishness Y N Too Hot/Cold other: _____</p>	<p>Integumentary</p> <p>Y N Rash/Itch Y N Change in Mole/Lesion Y N Breast Lump/Discharge other: _____</p>
<p>Cardiovascular</p> <p>Y N Chest Pain Y N Varicose Veins Y N Shortness of Breath Y N High Blood Pressure other: _____</p>	<p>Respiratory</p> <p>Y N Wheezing Y N Coughing Y N Shortness of Breath other: _____</p>	<p>Allergies/Immunization</p> <p>Y N Hay Fever Y N Drug Allergies other: _____</p>	<p>Musculoskeletal</p> <p>Y N Joint Pain Y N Neck Pain Y N Back Pain other: _____</p>
<p>Gastrointestinal</p> <p>Y N Abdominal Pain Y N Nausea/Vomiting Y N Indigestion/Heartburn Y N Blood/Change in Stool other: _____</p>	<p>Genitourinary</p> <p>Y N Painful Urination Y N Frequency of Urination Y N Fever/Chills other: _____</p>	<p>Sexual Problems</p> <p>Y N Abuse Y N Sex Drive Y N History of STD's</p>	<p>Except for the problems circled (Y), all other systems are negative</p> <p>Dr/NP/PA _____</p>

Sign

I authorize Valley OB/GYN to release information to insurance carriers regarding my medical care, and I hereby assign to Valley OB/GYN, all payments for services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance.

Patient or Guardian Signature _____ Date _____