**Centra Medical Group Women’s Center**

2007 Graves Mill Road

Forest, VA 24551

(434)385-8948

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you identify as: Straight Gay Lesbian Bisexual Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender identity: Female Transgender Male/Transman/FTM Transgender Female/Transwoman/MTF
 Non-Binary Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Decline to answer

|  |  |  |
| --- | --- | --- |
|  Diabetes Type 1 | Anxiety or Depression | Autoimmune disease |
|  Diabetes Type 2 | Thyroid disease: Hypothyroid | Ovarian cancer |
|  Polycystic Ovaries (PCOS) | Thyroid disease: Hyperthyroid | Uterine cancer |
|  High blood pressure | Ovarian cysts | Breast cancer |
|  Heart disease | Endometriosis | Colon cancer |
|  High Cholesterol | Uterine Fibroids | Melanoma |
|  Asthma | Osteoporosis | Pancreatic cancer |

Medical Historv (any new from last visit): None

 Alcohol/Drug abuse Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social History: Single Married Divorced Widowed

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student: Yes No School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you use alcohol? Yes No Previously How many times in the past year have you had 4 or more drinks in a day?\_\_\_\_\_

Do you use drugs? Yes No Previous1y What kind?How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Diet restrictions/Special diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### OB/GYN History

 Are you currently pregnant?  No First day of your last period:
 Age of first period: \_\_\_\_\_\_\_\_\_\_ How many days between periods? \_\_\_\_\_\_\_\_\_\_\_\_\_ How long do your periods last?

Cramping during periods? Yes No Flow: Heavy Medium Light Clots:  No
Pain level during periods mild or severe out of 10

Please describe your sexual activity in the past year (check all that apply):

I was in a monogamous relationship with a man (I had sex with only one man)
I was in a monogamous relationship with a woman (I had sex with only one woman)
I had more than one male partner
I had more than one female partner
I had both male and female partners
I did not have any sexual partners
Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you had the HPV vaccine? Yes No How many doses have you had? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you currently use to prevent pregnancy (contraception)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
What have you used previously? IUD Pills Condoms Patch Nuvaring Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in changing your method of contraception? Yes No

 Date of last pap test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last colonoscopy: \_\_\_\_\_\_\_\_\_

 How many times have you been pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of children? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last revised: 2/2021

Page 1 of 2

Pregnancy History

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of birth or miscarriage | Weeks | Vag/CSection | Pain Relief Used | F/M | Weight | Name | Place of Birth | Complications |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

Surgical History (any new from last visit) None

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Surgery | Date | Surgery |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |



### Medication (please include vitamins, over the counter medications) None

|  |  |  |
| --- | --- | --- |
| Medication  | Dose | How often do you take it?  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

### Medication and Food Allergies None

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Family Medical History (any new from last visit- please include relationship to you- i.e. parents, siblings. grandparents)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Diagnosis | Family Member | Diagnosis | Family Member | Diagnosis | Family Member |
| Diabetes |  | Melanoma |  | Osteoporosis |  |
| Stroke |  | Pancreatic cancer |  | Autoimmune disease |  |
| High blood pressure |  | Colon cancer |  | Hypothyroid |  |
| Heart disease |  | Ovarian cancer |  | Hyperthyroid |  |
| Depression/Mental Illness |  | Uterine cancer |  | Alcohol/Drug Abuse |  |
| Kidney disease |  | Breast cancer |  | Other |  |

Concerns or problems you'd like to discuss today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last revised 2/2021

Page 2 of 2