WELLNESS CONNECTIONS, L.L.C.

Nancy R.G. Church, M.D., FACOG

Patient's Name ______________________________ Date ______________

Reason for your visit today ______________________________

Past Medical History

(Do you have or have you ever had)

- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast Cancer
- ☐ Cardiac Arrhythmia
- ☐ Cervical Cancer
- ☐ Cholesterol, elevated
- ☐ Colon Cancer
- ☐ Congestive Heart Disease
- ☐ COPD (Lung Disease
- ☐ Coronary Heart Disease
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ DVT (Venous Embolism)
- ☐ Epilepsy
- ☐ Esophageal Reflux
- ☐ Fibromyalgia
- ☐ Hepatitis (A, B or C)
- ☐ Hernia
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Stone
- ☐ Lung Cancer
- ☐ Migraine Headache
- ☐ Mitral Valve Prolapse
- ☐ Myocardial Infarction
- ☐ Osteoporosis
- ☐ Ovarian Cancer
- ☐ Skin Cancer
- ☐ Stomach Cancer
- ☐ Stress Incontinence
- ☐ Stroke (CVA)
- ☐ Ulcer
- ☐ Uterine Cancer
- ☐ **NONE**

Comments:

Past Gynecological History

(Do you have or have you ever had) ☐ **NONE**

- ☐ Abnormal PAP smear
- ☐ Amenorrhea (no menses)
- ☐ Anovulation
- ☐ Bartholin's Gland Cyst
- ☐ Cervical Cancer
- ☐ Chlamydia
- ☐ Condyloma Acuminatum
- ☐ Cystocele (Dropped Bladder)
- ☐ DES Exposure in Utero
- ☐ Dysplasia (Abnormal PAP)
- ☐ Dysfunctional Bleeding
- ☐ Dysmenorrhea
- ☐ Dyspareunia (painful sex)
- ☐ Ectopic Pregnancy
- ☐ Endometriosis
- ☐ Fibroid Uterus
- ☐ Gonorrhea
- ☐ Herpes Simplex (HSV)
- ☐ Hirsutism
- ☐ Human Papilloma Virus (HPV)
- ☐ Incontinence
- ☐ Infertility
- ☐ Irregular Menses
- ☐ Menorrhagia
- ☐ Ovarian Cyst
- ☐ Pelvic Inflammatory Disease
- ☐ PMS
- ☐ Polycystic Ovaries (PCOS)
- ☐ Recurrent Vaginitis
- ☐ Syphilis
- ☐ Trichomonas
- ☐ Uterine Polyps
- ☐ Uterine Prolapse

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Past Surgical History

- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Breast Augmentation
- ☐ Breast Lumpectomy
- ☐ Breast Mastectomy
- ☐ Bladder Lift
- ☐ Cesearan Section
- ☐ CABG (coronary bypass)
- ☐ Cholecystectomy/Gallbladder
- ☐ Colon Resection
- ☐ Colonoscopy
- ☐ Cystoscopy
- ☐ D & C
- ☐ Ectopic Pregnancy
- ☐ Endometrial Ablation
- ☐ Gastic Bypass
- ☐ Hemorrhoid
- ☐ Hernia
- ☐ Hip Replacement
- ☐ Hysteroscopy
- ☐ Hysterectomy (abdominal)
- ☐ Hysterectomy (vaginal)
- ☐ Hysterectomy (laproscopic)
- ☐ Knee Surgery
- ☐ Laparoscopy
- ☐ Ovary Removal
- ☐ Pacemaker Implant
- ☐ Shoulder Surgery
- ☐ Splenectomy
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ **NONE**

Comments:

Medications

☐ **NONE**

Name of Medication Currently Taking	Dosage	Frequency	Reason for Taking

Allergies

☐ **NONE**

Allergen	Reaction

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Reproductive & Menstrual History

☐ **NONE**

Total # of Pregnancies	Total # of Full Term Deliveries	Total # of Premature Deliveries	Total # of Multiple Births
Total # of Terminations	**Total # of Miscarriages**	**Total # of Ectopic Pregnancies**	**Total # of Children Living**

Date of Delivery	Weeks Gestation	C-Section or Vaginal	Weight of Baby	Anesthesia	Complications

Date of Last Menstrual Period ____________________
At what age did your menstrual cycle begin? _________

Menopause Status ___________
On Hormone Replacement YES NO

Yes	No		
☐	☐	Are your periods regular?	If irregular, how so? ____________________
☐	☐	Any recent changes with your periods?	If so, what are they? ____________________
☐	☐	Do you spot or bleed between your periods?	
☐	☐	Do you spot or bleed after intercourse?	

How many days between your periods? ____________
How many days does your period last? ____________
Are your periods light, medium or heavy? ____________

Current method of birth control ______________________

Genetic History

☐ Chromosomal Disorder
☐ Cystic Fibrosis
☐ Sickle Cell Anemia
☐ Genetic/Inherited Disorder
☐ Baby with Birth Defects
☐ Mental Retardation
☐ Down's Syndrome
☐ Neural Tube Defects
☐ **NONE**

Comments:

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General Health Screening

Date of last PAP Smear ____________ Date of last Colonoscopy ____________

Date of last Mammogram ____________ Date of last Bone Density Scan ____________

Yes	No			
☐	☐	Do you smoke?	If so, how much? ____	For how long ____
☐	☐	Have you ever smoked?	If so, how much? ____	For how long ____
☐	☐	Do you drink regularly?	If so, how many drinks per week? ____________	
☐	☐	Do you use other recreation drugs?	If so, which ones? ____________	
☐	☐	Do you exercise regularly?		
☐	☐	Do you perform a monthly breast exam?		
☐	☐	Are you sexually active?	If so, how many partners have you had? ________	
☐	☐	Is sex satisfactory?	If not, what are your complaints? ____________ ____________	
☐	☐	Have you ever had a colposcopy?	If so, when? ____________	
☐	☐	Have you had the Gardasil vaccine?	If so, did you complete the series? ____________	
☐	☐	Do you eat 3 meals per day?		
☐	☐	Do you eat snacks regularly?		
☐	☐	Do you have any eating problems?		
☐	☐	Any diet preferences/restrictions?	If so, what types? ____________	

Number of servings per day of vegetables & fruits ______
Number of servings per day of grains ______
Number of servings per week of red meat ______
Number of servings per day of dairy ______
Number of caffeinated beverages per day ______

Social History

What is your marital status? ____________
What is your occupation? ____________
Highest grade level achieved? ____________

Yes	No	
☐	☐	Do you wear seatbelts?
☐	☐	Have you ever had a drug problem?

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Family History

Yes	No		Relationship	Age Diagnosed
☐	☐	Breast Cancer	______	______
☐	☐	Ovarian Cancer	______	______
☐	☐	Uterine Cancer	______	______
☐	☐	Male Breast Cancer	______	______
☐	☐	Cervical Cancer	______	______
☐	☐	Colon Cancer	______	______
☐	☐	Other Cancer	______	______
☐	☐	Osteoporosis	______	______
☐	☐	Hypertension	______	______
☐	☐	Heart Attack	______	______
☐	☐	Stroke	______	______
☐	☐	Diabetes	______	______
☐	☐	Mental Illness	______	______
☐	☐	Obesity	______	______
☐	☐	Alcoholism	______	______
☐	☐	Epilepsy or seizures	______	______
☐	☐	Gallstones	______	______
☐	☐	Glaucoma	______	______
☐	☐	Bleeding problems	______	______
☐	☐	Other	______	______