IHA

IHA DIVISION OF OB-GYN
REVIEW OF SYSTEMS
New Patient

NAME: _____ **AGE** _____

Date of Birth: _____

What are the reasons for your visit today?

Do you have any of the following health problems now or in the past?

Yes		Explain
☐	Abuse (physical/emotional)	
☐	Anxiety or depression	
☐	Asthma	
☐	Back pain	
☐	Blood Clots	
☐	Blood in Urine	
☐	Bloody/dark stools	
☐	Cancer	
☐	Chest Pain	
☐	Constipation	
☐	Convulsions	
☐	Diabetes	

Yes		Explain
☐	Frequent Urination	
☐	Gall bladder disease	
☐	Headaches	
☐	Hearing/vision problems	
☐	Heart murmur	
☐	High blood pressure	
☐	Kidney disease	
☐	Sexual concerns	
☐	Shortness of breath	
☐	Stroke	
☐	Thyroid disease	
☐	Ulcers/indigestion	

Health Risk Factors:

Do you?:	Yes	No	
Do self breast exam?	☐	☐	
Any changes?	☐	☐	
Exercise regularly?	☐	☐	
Type_____ Freq_____			
Smoke?	☐	☐	Cigs/day_____
Consume Alcohol?	☐	☐	Drinks/wk _____
Use recreational drugs?	☐	☐	
Use sunscreen regularly?	☐	☐	
Wear seat belts?	☐	☐	
Eat dairy products daily?	☐	☐	Servings/day ____
Eat fruits & vegetables daily?	☐	☐	
Follow a low-fat diet?	☐	☐	
Take calcium supplements?	☐	☐	
Take vitamin supplements?	☐	☐	

Menstrual History:
Age at first period____ First day of last period____ /____ /____
Cycle length: ____days Flow____days ☐heavy ☐mod ☐light

Has anyone in your family had the following:	Who?
Heart attack	
Diabetes	
High blood pressure	
Osteoporosis	
Colon cancer	
Breast cancer	
Uterine cancer	
Ovarian cancer	
Birth defects	
Other: _____	

Do you have any Medication or Latex Allergies?

Medication	Reaction

Please list your current medications, dose, and how often you take them (include herbs, vitamins, and supplements):

Medication	Dose	Frequency Taken

Have you ever had any of the following gyn history? **Explain**

- ☐ Herpes
- ☐ Gonorrhea/Chlamydia
- ☐ Genital Warts
- ☐ Abnormal pap smear
- ☐ IUD in the past
- ☐ Current birth control method _____

Date of last pap smear _____ /_____ / _____
Date of last mammogram _____/ _____ / _____

Have you ever had prior Surgery?

Year	Procedure

Have you ever had any prior pregnancies?

Year	Type birth	Wt.	Complications

Signature:_____ **Date:** ____/____/_____