GYN History

Date:_____ Chart #:_____
Patient Name:_____ Date of Birth:_____
Address:_____ Primary Language: _____
City/State/Zip:_____
Telephone Number:_____

What are you being seen for today: _____

How many pregnancies have you had? _____

Any miscarriages Yes No If yes, how many? _____ What year(s)? _____
Any elective abortions? Yes No If yes, how many? _____ What year(s)? _____
Any ectopic (tubal) pregnancies? Yes No If yes, how many? _____ What year(s)? _____
Any still births? Yes No If yes, how many? _____ What year(s)? _____
Please list the cause of still birth(s), if known: _____
Any children born with birth defects? Yes No If yes, how many? _____ What year(s)? _____
If yes, please specify: _____

What was the first day of your last period? _____
How old where you when your period started? _____
How often do you have periods? _____
How many days do your periods last? _____
Do you have cramping during your period? Yes No
Your periods are (please circle) Heavy Light Regular
Do you have premenstrual symptoms? Bloating Swelling Headaches Breast Tenderness
Please specify any other symptoms you may have: _____
Do you have spotting in between periods? Yes No

What are you using for birth control (please circle all that apply)

Abstinence	Condoms	Foam	IUD – Paragard	Tubal Coils
Barrier	Contraceptive Patch	Hysterectomy	Natural Family Planning	Vaginal Ring
Bilateral Tubal	Depo Provera	Nexplanon	Rhythm	Vasectomy
Birth Control Pills	Diaphragm	IUD – Mirena	IUD – Skyla	Withdrawal

If you are taking birth control pills, what is the brand name? _____
How long have you been taking birth control pills? _____
Have you had any problems with them? Yes No
If yes, please explain: _____

When was your last pap smear? _____ Results were: Normal Abnormal
When was your last mammogram? _____ Results were: Normal Abnormal
Do you perform self-breast exams? Yes No
When was your last colonoscopy? _____ Results were: Normal Abnormal
When was your last bone scan? _____ Results were: Normal Abnormal

Preferred Pharmacy and Location: _____
Primary Care Physician: _____ Insurance Coverage: _____

SAN DIMAS MEDICAL GROUP, INC.
SERVING KERN COUNTY SINCE 1973

OBSTETRICS & GYNECOLOGY
Marietta Marzan-Tan, M.D.
Wendy C. Crenshaw, M.D.
Tillai Kannappan, M.D.
Gregory R. Klis, M.D.
James M. Tsai, M.D.
Noel G. Del Mundo, M.D.
Jacqueline Williams-Olango, M.D.
Luis Lopez, M.D.
Sauhang Patel, M.D.
Callie Blair, D.O.

PHYSICIAN ASSISTANT
Rhonda Colvin, PA-C
Anna Nazaryan, PA-C
Kristin Chisum, PA-C

NURSE PRACTITIONER
Anne Graham, FNP-C
Norma Mejia, FNP-C
Jennifer Roman, FNP-C
Toni-Ann McEnroe, OB/GYN NP-C

100 Old River Road
Bakersfield, California 93311
(661) 663-4800 Phone
(661) 663-4770 Fax

Do you have vaginal discharge? Yes No

If yes, is the color Grey Brown Yellow Other:_____

Is the discharge (please circle) Heavy Light Normal

Is the discharge (please circle) Watery Thick Normal Cheesy White Bloody

Do you have bleeding after intercourse? Yes No

Is intercourse painful? Yes No

If yes, please explain? _____

Are you allergic to any medications? Yes No

If yes, please list the medications and your reaction:

Medication	Reaction

Are you currently taking any medications? Yes No

If yes, please list the medications and their dosage:

Medication	Dose	Treatment for

Pregnancy History

Day / Month / Year	Was Pregnancy		Was Delivery (please list gestation wks)		Delivering Physician	Delivery Vaginal or C-Section	Sex of Child	Birth Weight	**Complications
	Miscarriage	Elective Abortion	Full Term	Pre Term					
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No

** If you noted “Yes” to Complications, please specify year and type of event (i.e., miscarriage, ectopic, elective abortion)

_____

_____

Medical History

Please list any medical conditions you have been or are currently being treated for: _____

_____

_____

Genetic History

Certain genetic diseases are common in some ethnic groups. Please help us to determine your risk factors.

Are you or your partner of African American Ancestry? Yes No

If yes, have either of you been tested for Sickle Cell trait (Sickle Cell Anemia carrier?) Yes No

Are you or your partner of Easter European Jewish decent? Yes No Ashkenazi? Yes No

If yes, have either of you been tested to see if you are a Tay-Sachs carrier? Yes No

Are you or your partner of Asian Mediterranean (Greek, Italian, etc.) decent? Yes No

Are you or your partner adopted? Yes No

If yes, is there a family history available? Yes No

Have you or your partner been exposed to blood and body fluids of individuals with:

HIV, Hepatitis C, or Hepatitis B? Yes No

Past Surgical History

Please list any and all of your surgeries:

Year	Type of Surgery	Reason for Surgery

Social History

Do you currently use illicit drugs? Yes No If yes, please list: _____

Do you have a history of drug abuse? Yes No If yes, please list: _____

Do you drink? Yes No If yes, how often? _____ How many per day? _____

Are you currently sexually active? Yes No

What is your marital status? Single Married Living with Partner Separated Divorced

What is your ethnicity? (please circle)

African American Hispanic Asian / Filipino American Indian (or Alaskan Native)

Native Hawaiian / Pacific Islander Unknown Other: _____

What is your occupation? _____

In your occupation, are you potentially exposed to infectious diseases or hazardous materials? Yes No

If yes, please list all materials you are potentially exposed to: (i.e. radiation, biohazards, chemicals) _____

Do you smoke? Yes No If yes, how many per day? _____

Do you use caffeine? Yes No

Do you exercise? Yes No If yes, do you exercise (please circle) Daily Weekly Seldom

Family History

Please list family members' medical conditions (please include parents and siblings)

**Do NOT include in-laws or adopted parents or siblings.

**Be sure to list any immediate family members with any history of breast, cervical, ovarian, uterine, or colon cancer.

Relative Type (Father, Mother, Siblings)	Living / Deceased	If deceased, age at death	Illnesses / Disorders

Date of last Immunization or vaccine:

Tdap: _____

Gardasil: _____

Influenza (flu): _____

Other: _____