

OB GYN

Maria Smith, MD, FACOG
Suzanne Rashidian, DO, FACOOG

FAMILY PRACTICE

Stacey Fazenbaker, MD, IFMCP

FUNCTIONAL MEDICINE

Stacey Fazenbaker, MD, IFMCP

NURSE PRACTITIONERS

Emily Clark, APRN
Jennifer Meunier, APRN

AESTHETICS

Brooke Waninger-White, MA, CLT

NAME: _____

DOB: ___/___/___ DATE: ___/___/___

AGE: _____ MARITAL STATUS: _____

Who referred you to our office? _____

What issue(s) would you like to discuss with the doctor today? _____

Who is your primary care doctor? _____

<p>History</p> <p>Obstetrical History: Please indicate the number of each</p> <p>#Pregnancies _____</p> <p>#Preterm Births _____</p> <p>#Miscarriages _____</p> <p>#Tubal Pregnancies _____</p> <p>#Terminations _____</p> <p>#Living Children _____</p> <p>#Vaginal Deliveries _____</p> <p>#Cesarean Sections _____</p> <p>Gynecological History: Circle if you have been diagnosed or treated for any of the following:</p> <p>Infertility _____</p> <p>Abnormal Pap Smear _____</p> <p>Sexually Transmitted Disease _____</p> <p style="padding-left: 20px;">Gonorrhea Trichomonas HIV</p> <p style="padding-left: 20px;">Chlamydia Syphilis Genital Warts</p> <p>PID (pelvic inflammatory disease) _____</p> <p>Endometriosis _____</p> <p>Medical History: List any medical problems you take medications for or see a doctor for regularly.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Surgical History: Have you had a hysterectomy? Y N</p> <p style="padding-left: 20px;">Were your ovaries removed? Y N</p> <p>List all other major surgeries: _____</p> <p>_____</p> <p>_____</p> <p>Social History:</p> <p>Do you smoke? Y N</p> <p>Do you drink alcohol? Y N</p> <p>Use illicit drugs? Y N</p> <p style="padding-left: 20px;">Marijuana Cocaine Amphetamines</p> <p style="padding-left: 20px;">Heroin Other</p> <p>What is your occupation? _____</p> <p>Highest level of education? _____</p> <p>Do you eat a balanced diet? Y N</p> <p>Do you exercise regularly? Y N</p> <p>Have you ever been abused?</p> <p style="padding-left: 20px;">Mentally? Y N</p> <p style="padding-left: 20px;">Physically? Y N</p> <p style="padding-left: 20px;">Sexually? Y N</p> <p>Family History: Please circle if your family (parents, grandparents, brothers sisters) have been diagnosed with the following:</p> <table style="width: 100%; border: none;"> <tr> <td>Bleeding Disorder</td> <td>Breast Cancer</td> <td>Clotting Disorder</td> </tr> <tr> <td>Gynecologic Cancer</td> <td>Colon Polyps</td> <td>Heart Disease</td> </tr> <tr> <td>Colon Cancer</td> <td>Diabetes</td> <td>Prostate Cancer</td> </tr> <tr> <td>Stroke</td> <td>Osteoporosis</td> <td>Other Genetic Disease(s):</td> </tr> </table>	Bleeding Disorder	Breast Cancer	Clotting Disorder	Gynecologic Cancer	Colon Polyps	Heart Disease	Colon Cancer	Diabetes	Prostate Cancer	Stroke	Osteoporosis	Other Genetic Disease(s):	<p>Medications: List all medications you take on a regular basis</p> <p>_____</p> <p>_____</p> <p>Allergies: List any allergies to medications</p> <p>_____</p> <p>_____</p> <p>Screening: List the last year each was performed</p> <p>Mammogram: _____</p> <p>PAP Smear: _____</p> <p>Cholesterol Screening: _____</p> <p>Colonoscopy: _____</p> <p>Bone Mineral Density: _____</p> <p>Menstrual History:</p> <p>The first day of your last menstrual period? _____</p> <p>Age of first menstrual period? _____</p> <p>Average number of days between the start of your menstrual periods? _____</p> <p>Number of days you have bleeding? _____</p> <p>Please circle any symptoms that you have recently experienced?</p> <table style="width: 100%; border: none;"> <tr> <td>Abnormal discharge/odor</td> <td>Bleeding after intercourse</td> </tr> <tr> <td>Heaving bleeding/clots</td> <td>Pain with intercourse</td> </tr> <tr> <td>Excessively painful periods</td> <td>Difficulty with orgasm</td> </tr> <tr> <td>Excessive cramping</td> <td>Decreased interest in sex</td> </tr> <tr> <td>Diagnosed with Endometriosis</td> <td></td> </tr> <tr> <td>Excessive pelvic/abdominal pain</td> <td></td> </tr> <tr> <td colspan="2"> </td> </tr> <tr> <td>Pain/burning with urination</td> <td>Frequent constipation</td> </tr> <tr> <td>Blood/Pus in urine</td> <td>Frequent diarrhea</td> </tr> <tr> <td>Leaking urine with activity</td> <td>Pain with bowel movements</td> </tr> <tr> <td>Frequent or urgent urination</td> <td>Blood in stool</td> </tr> <tr> <td>Excessive urination at night</td> <td>Abnormal colonoscopy</td> </tr> </table> <p>Please circle any symptoms you are currently experiencing:</p> <table style="width: 100%; border: none;"> <tr> <td>Constitutional</td> <td>Psychiatric</td> </tr> <tr> <td>Bad headaches</td> <td>Depression</td> </tr> <tr> <td>Fatigue</td> <td>Anxiety</td> </tr> <tr> <td>Weight Loss</td> <td>Eating Disorder</td> </tr> <tr> <td>Weight Gain</td> <td></td> </tr> <tr> <td colspan="2"> </td> </tr> <tr> <td>HEENT</td> <td>Neurologic</td> </tr> <tr> <td>Blurry Vision</td> <td>Seizures</td> </tr> <tr> <td>Bleeding Gums</td> <td>Migraines</td> </tr> <tr> <td>Thyroid Problems</td> <td>Numbness</td> </tr> <tr> <td colspan="2"> </td> </tr> <tr> <td>Heart</td> <td>Musculoskeletal</td> </tr> <tr> <td>Irregular Heartbeat</td> <td>Back Pain/Disc Disease</td> </tr> <tr> <td></td> <td>Joint Pain</td> </tr> <tr> <td>Lung</td> <td>Blood/Circulation</td> </tr> <tr> <td>Shortness of breath</td> <td>Frequent Nose Bleeds</td> </tr> <tr> <td>Asthma/ Wheezing</td> <td>Bleeding Gums</td> </tr> <tr> <td>Persistent Cough</td> <td>High Cholesterol</td> </tr> </table>	Abnormal discharge/odor	Bleeding after intercourse	Heaving bleeding/clots	Pain with intercourse	Excessively painful periods	Difficulty with orgasm	Excessive cramping	Decreased interest in sex	Diagnosed with Endometriosis		Excessive pelvic/abdominal pain				Pain/burning with urination	Frequent constipation	Blood/Pus in urine	Frequent diarrhea	Leaking urine with activity	Pain with bowel movements	Frequent or urgent urination	Blood in stool	Excessive urination at night	Abnormal colonoscopy	Constitutional	Psychiatric	Bad headaches	Depression	Fatigue	Anxiety	Weight Loss	Eating Disorder	Weight Gain				HEENT	Neurologic	Blurry Vision	Seizures	Bleeding Gums	Migraines	Thyroid Problems	Numbness			Heart	Musculoskeletal	Irregular Heartbeat	Back Pain/Disc Disease		Joint Pain	Lung	Blood/Circulation	Shortness of breath	Frequent Nose Bleeds	Asthma/ Wheezing	Bleeding Gums	Persistent Cough	High Cholesterol
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