# Summit
MEDICAL SPECIALISTS

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**OB GYN**

Sydni Crowell, MD
Suzanne Rashidian, DO, FACOOG

**INTERNAL MEDICINE**

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**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?_____________

**History**

**Obstetrical History:** Please indicate the number of each
- #Pregnancies _______
- #Preterm Births _______
- #Miscarriages _______
- #Tubal Pregnancies _______
- #Terminations _______
- #Living Children _______
- #Vaginal Deliveries _______
- #Cesarean Sections _______

**Gynecological History:** Circle if you have been diagnosed or treated for any of the following:
- Infertility
- Abnormal Pap Smear
- Sexually Transmitted Disease
  - Gonorrhea Trichomonas HIV
  - Chlamydia Syphilis Genital Warts
- PID (pelvic inflammatory disease)
- Endometriosis

**Medical History:** List any medical problems you take medications for or see a doctor for regularly.
___________________________________________________
___________________________________________________
___________________________________________________

**Surgical History:** Have you had a hysterectomy? Y N
Were your ovaries removed? Y N
List all other major surgeries:______________________
___________________________________________
___________________________________________

**Social History:**
- Do you smoke? Y N
- Do you drink alcohol? Y N
- Use illicit drugs? Y N
  - Marijuana Cocaine Amphetamines
  - Heroin Other
- What is your occupation? __________________
- Highest level of education? __________________
- Do you eat a balanced diet? Y N
- Do you exercise regularly? Y N
- Have you ever been abused?
  - Mentally? Y N
  - Physically? Y N
  - Sexually? Y N

**Family History:** Please circle if your family (parents, grandparents, brothers sisters) have been diagnosed with the following:

| | | |
|---|---|---|
| Bleeding Disorder | Breast Cancer | Clotting Disorder |
| Gynecologic Cancer | Colon Polyps | Heart Disease |
| Colon Cancer | Diabetes | Prostate Cancer |
| Stroke | Osteoporosis | Other Genetic Disease(s): |

**Medications:** List all medications you take on a regular basis
___________________________________________________
___________________________________________________

**Allergies:** List any allergies to medications
___________________________________________________
___________________________________________________

**Screening:** List the last year each was performed
- Mammogram: ____________________
- PAP Smear: ____________________
- Cholesterol Screening: ____________________
- Colonoscopy: ____________________
- Bone Mineral Density: ____________________

**Menstrual History:**
- The first day of your last menstrual period? ____________
- Age of first menstrual period? ____________
- Average number of days between the start of your menstrual periods? ____________
- Number of days you have bleeding? ____________

**Please circle any symptoms that you have recently experienced?**

| | |
|---|---|
| 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 |

**Please circle any symptoms you are currently experiencing:**

**Constitutional**
- Bad headaches
- Fatigue
- Weight Loss
- Weight Gain

**Psychiatric**
- Depression
- Anxiety
- Eating Disorder

**HEENT**
- Blurry Vision
- Bleeding Gums
- Thyroid Problems

**Neurologic**
- Seizures
- Migraines
- Numbness

**Heart**
- Irregular Heartbeat

**Musculoskeletal**
- Back Pain/Disc Disease
- Joint Pain

**Lung**
- Shortness of breath
- Asthma/ Wheezing
- Persistent Cough

**Blood/Circulation**
- Frequent Nose Bleeds
- Bleeding Gums
- High Cholesterol