ROSA GYNECOLOGY

Today's Date: _____

Name: _____ Date of Birth _____ Age: _____

Reason for Today's visit _____

Menstrual History:
First Day of Last Menstrual Period:_____ Age at First Menstrual Period:_____ Years
Number of days from the start of one period to the start of the next:_____ days
Number of days that you bleed:_____days
Describe the amount of menstrual flow (circle one) ____ light / moderate / heavy / clots
How many tampons or pads do you use on your heaviest day? _____
Describe the amount of menstrual discomfort (circle one) __ none / mild / moderate / severe
Do you bleed in between your periods? (circle one) Yes No
Do you bleed after intercourse? (circle one) Yes No
If you stopped menstruating, at what age did you stop? _____years
Have you had bleeding or spotting since your periods stopped? (circle one) Yes No

Contraceptive and Sexual History:
Present birth control method: _____
Birth Control Methods used in the past:

	Method	Length of Use	Reason for Discontinuation
1)			
2)			
3)			

Are you or have you ever been sexually active (had intercourse)? (circle one) Yes No
Have you had a new sexual partner in the past three months? (circle one) Yes No
Is/Are your sexual partner(s) male, female or both? (circle one) Male Female Both
Do you experience pain or discomfort with sexual intercourse? (circle one) Yes No

Pap Smear/Mammogram History
Date of Last Pap Smear_____ Have you had abnormal pap smears? (circle one) Yes No
Have you had treatment for abnormal smears? (circle one) Yes No
If yes, what type(s) of treatment have you had?
Cryotherapy Year _____ Laser Year_____

Cone Biopsy Year _____ Loop Excision (LEEP) Year_____

Other Past Gynecology History: Circle any that apply: None Pelvic Inflammatory Disease Endometriosis
Venereal Warts Herpes-genital Syphilis Gonorrhea Chlamydia
Vaginal Infections Other_____

Date of last mammogram Month _____ Year_____
Have you had an abnormal mammogram? (circle one) Yes No

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Name:_____ DOB:_____ Date:_____

Obstetrical History: Please record the number of:

Pregnancies _____ Vaginal Births_____ Miscarriages _____
Living Children _____ C-Sections _____ Abortions _____
List any complications of pregnancies: _____
_____

Medical History: Please check if you or a blood-relative have had any of the following:

	Myself	Family		Myself	Family		Myself	Family
Anemia	_____	_____	Mental Illness	____	____	Liver Disease/Hepatitis	_____	_____
High Blood Pressure	_____	_____	Depression	____	____	Gall Bladder Disease	_____	_____
High Cholesterol	_____	_____	Anxiety	____	____	Blood Clots in Veins/Lungs	_____	_____
Heart Disease	_____	_ ____	Eating Disorder	____	____	Blood Transfusion	_____	_____
Stroke	_____	_____	Migraine Headaches	____	____	Breast Cancer	_____	_____
Diabetes	_____	_____	Urinary Tract Infection	____	____	Colon Cancer	_____	_____
COPD/Emphysema	_____	_____	Lupus	____	____	Uterine Cancer	_____	_____
Asthma	_____	_____	Arthritis	____	____	Ovarian Cancer	_____	_____
Seizures	. _____	_____	Back Injury	____	____	Other Cancer, specify	_____	_____
Thyroid problems	_____	_____	Osteoporosis	____	____			

Other Medical Problems: (List all)_____
_____

Past Obstetrical/Gynecological Surgeries None _____

	Year		Year
D&C	_____	**Ovarian Surgery**	_____
Hysteroscopy	_____	**L cyst(s) removed ovarian**	_____
Infertility Surgery	_____	**R cyst(s) removed ovarian**	_____
Tubal Ligation	_____	**L ovary removed**	_____
Laparoscopy	_____	**R ovary removed**	_____
Hysterectomy (Vaginal)	_____	**Vaginal or Bladder Repair**	_____
Hysterectomy (Abdominal)	_____	**For prolapsed or incontinence**	_____
Myomectomy	_____	**Cesarean section**	_____
		Other	_____

_____

Past Surgical History (Not Ob/Gyn)
List all surgeries and their year or None_____

Surgeries	Year	Surgeries	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there any other information you feel we should have:

_____
_____
_____

Patient Signature_____ Date_____ Provider Signature _____ Date_____

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MEDICATION RECONCILIATION FORM

Patient Name: _____

Medications Listed By: _____ Date: _____ DOB: _____

(Relationship if other than patient)

Allergies & Reactions: _____

MEDICATIONS (Prescription, Over the Counter, Herbal Supplements and Vitamins)	Indication Reason for Taking this Medication	Dose 1 tab, 2 tabs, etc.	Route By mouth, subQ, rectal	Frequency (How often do you take your medication)
Patient takes no medications ☐				

PHYSICIAN'S ORDER SIGNATURE: _____

DATE: _____