Summit
OBSTETRICS & GYNECOLOGY, PSC
A Comprehensive Center For Women

Physician:
□ **Maria E. Smith, MD, FACOG**
□ **Suzanne M. Rashidian, DO, FACOOG**
□ **Emily Clark, APRN**

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	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