Lorraine M. Dodson, M.D.
Brian T. Stephens, M.D.

Women's Clinic of JCMG

Brandi Nichols, M.D.
Jodi A. Berendzen, M.D.
Amanda T. Rodemann, D.O.

Name: _____ **Date of Birth:** _____

Medications: Please list **ALL** current medications, **including** vitamins and herbal supplements

Medication	Reason for medication	Amount/Dose	How many times daily	Who prescribed this medication?

Allergies: Please list **ALL** allergies, **including** allergies to latex and iodine/Betadine

☐ **No Known Drug Allergies**

Drug Name	Reaction

Current and Past Medical History: Please indicate current/prior medical problems

☐ **No Significant Medical Problems**

☐ Anemia _____
☐ Anesthesia complications _____
☐ Anxiety _____
☐ Arthritis _____
☐ Asthma _____
☐ Autoimmune disorder (Lupus) _____
☐ Blood clots _____
☐ Blood transfusion _____
☐ Cancer _____
☐ Depression _____
☐ Diabetes _____
☐ Gynecological disorder _____
☐ Other _____
☐ Heart disease _____
☐ Hepatitis or Liver disease _____
☐ High blood pressure _____
☐ Infertility _____
☐ Kidney disease _____
☐ Muscle or skeletal problems _____
☐ Osteoporosis _____
☐ Seizures _____
☐ Stomach or intestinal problems _____
☐ Stroke _____
☐ Thyroid disease _____
☐ Tuberculosis _____

Family Medical History: Please only include parents, brothers, sisters, and grandparents

- ☐ **No Significant Medical Problems**
- ☐ Anemia _____
- ☐ Anesthesia complications _____
- ☐ Anxiety _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Autoimmune disorder (Lupus) _____
- ☐ Blood clots _____
- ☐ Blood transfusion _____
- ☐ Cancer _____
  - ☐ Breast Cancer _____
  - ☐ Ovarian Cancer _____
  - ☐ Colon Cancer _____
  - ☐ Other _____
- ☐ Depression _____
- ☐ Other _____
- ☐ Diabetes _____
- ☐ Gynecological disorder _____
- ☐ Heart disease _____
- ☐ Hepatitis or Liver disease _____
- ☐ High blood pressure _____
- ☐ Infertility _____
- ☐ Kidney disease _____
- ☐ Muscle or skeletal problems _____
- ☐ Osteoporosis _____
- ☐ Seizures _____
- ☐ Stomach or intestinal problems _____
- ☐ Stroke _____
- ☐ Thyroid disease _____
- ☐ Tuberculosis _____

Surgical History: Please list **ALL** surgeries, including procedures to the cervix.

Procedure	Date

Gynecological History:

Age at first period: _____
Cycle interval: _____
Days of flow: _____
Amount of flow: ☐ Heavy ☐ Moderate ☐ Light
Clots with cycle: ☐ Yes ☐ No
Bleeding between periods: ☐ Yes ☐ No
Method of birth control: _____

First day of last period: _____
Last pap: _____
History of abnormal Pap smear: _____
Age of menopause: _____
Have you used hormone replacement therapy:
☐ Yes ☐ No

Pregnancy History:

Total number of pregnancies: _____
Number of deliveries: _____
Number of preterm deliveries: _____

Miscarriages: _____
Abortions: _____
Ectopic pregnancies: _____

Children:

Name	DOB	Birth Weight	Sex	Vaginal or C-Section	Anesthesia	Early Labor	Complications	Location

Social History: Please indicate the term that best describes your habits.

Marital status:	☐ Married	☐ Single	☐ Divorced	☐ Widow
Alcohol Use:	☐ Never	☐ Occasional	☐ Frequent	
Smoker:	☐ Never	☐ Prior	☐ Current	
Drug Use:	☐ Never	☐ Prior	☐ Current	
Caffeine Use:	☐ None	☐ 1-2 drinks/day	☐ 3 or more drinks/day	
Exercise:	☐ None	☐ Sporadic	☐ 1-2x/week	☐ 3+times/week
Seatbelt Use:	☐ Not regular	☐ Always		
Self Breast Exam:	☐ Never	☐ Irregular	☐ Regular (monthly)	
Domestic Violence:	☐ Never	☐ Prior	☐ Current	
Diet:	☐ <1000mg Calcium daily		☐ 1000mg Calcium daily	

Review of Systems: Please indicate if you have had any recent trouble with the following issues.

☐ **No Problems**

General Health:			
☐ Fever	☐ Weight gain	☐ Weight loss	☐ Fatigue
Skin:			
☐ Rashes	☐ Changes to skin or nails		
Eyes:			
☐ Blurry vision	☐ Impaired vision	☐ Dryness	
Ears, Nose, Throat:			
☐ Hearing loss	☐ Constant ringing	☐ Nosebleeds	☐ Sinus pain
☐ Trouble swallowing			
Lungs:			
☐ Shortness of breath	☐ Wheezing	☐ Cough	☐ Apnea
Cardiovascular:			
☐ Chest pain	☐ Irregular heartbeat	☐ Fainting	☐ Ankle swelling
Gastrointestinal:			
☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation
☐ Blood in stool	☐ Heartburn		
Urinary:			
☐ Frequent urination	☐ Urinating at night	☐ Urgency	☐ Painful urination
Muscles and Joints:			
☐ Joint pain	☐ Back pain	☐ Muscle pain	
Nervous System:			
☐ Tremors	☐ Memory loss	☐ Headaches	
Endocrine:			
☐ Heat Intolerence	☐ Cold Intolerence		
Blood:			
☐ Anemia	☐ Easy bleeding/bruising		