



*The  
Thayer Group*  
*for*  
Women's Care, PC

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1155 Alpine Avenue • Suite 230 • Boulder, CO 80304

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

DATE: \_\_\_\_\_

Please help us provide you with the best health care possible. Complete and accurate information assists us with diagnosis and treatment. Please be as thorough as possible in completing this form and look up information about which you are not sure. It may be helpful to obtain health care records and bring them with you to your visit. It is a good idea to keep a copy of this completed form in your medical records and share it with your other doctors.

## I. CHIEF COMPLAINT

Please list the main reason for your visit today and other specific concerns or problems you want the doctor/practitioner to discuss with you.

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## II. OB/GYN HISTORY

Date of last menstrual period \_\_\_\_\_

Age at first period \_\_\_\_\_

Are your periods regular? \_\_\_\_\_

Are your periods heavy? \_\_\_\_\_

Any recent change in your periods? \_\_\_\_\_

Do you spot between periods? \_\_\_\_\_

Do you have premenstrual symptoms? \_\_\_\_\_ If so what? \_\_\_\_\_

Do you have menstrual cramps? \_\_\_\_\_

Are you menopausal?  Yes  No

If yes, what was the date of last menses? \_\_\_\_\_

Are you taking any hormones? \_\_\_\_\_

Do you have any vaginal bleeding? \_\_\_\_\_

Are you sexually active?  Yes  No

If yes, do you have pain with intercourse? \_\_\_\_\_

Do you have bleeding with intercourse? \_\_\_\_\_

How many sex partners have you had in the past year? \_\_\_\_\_

Have you had any gynecological surgeries? \_\_\_\_\_

(Hysterectomy, Bladder Repair, Cryosurgery, LEEP, Diagnostic, Other)

Have you had any other gynecological illnesses, problems or symptoms in the past or currently?

If yes, list problems and a brief description of any treatments you received  
(including abnormal pap smears).

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NAME \_\_\_\_\_

**CONTRACEPTIVE HISTORY** [Birth Control includes rhythm, oral contraceptives, condoms, withdrawal, IUD's, tubal ligation, etc.]

List types of birth control used	From when to when	Reason Discontinued
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PREGNANCY HISTORY**

Date pregnancy completed	Length of pregnancy In weeks	Vaginal Birth or C- Section	Sex & Weight	Complications
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Premature Births	_____	Elective abortions	_____
Miscarriages	_____	Ectopic pregnancies	_____
Still births	_____	Twins, Triplets, etc.	_____
Adopted children	_____	Step Children	_____

**III. PAST MEDICAL HISTORY**

<b>SURGERIES</b>	Date		
Tonsils	_____	Biopsies	_____
Appendectomy	_____	Wisdom Teeth	_____
Cancers	_____	Gallbladder	_____
Other	_____		_____
	_____		_____

**HOSPITALIZATIONS** (other than for surgeries)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRESENT MEDICATIONS** (Prescription and over the counter)

Name	Dose	# Taken Daily	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Aspirin \_\_\_\_\_

Herbs and Supplements: \_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES**

Are you allergic to any:  
Medications \_\_\_\_\_ What reaction: \_\_\_\_\_  
\_\_\_\_\_

Other Substances, Foods, etc: \_\_\_\_\_  
\_\_\_\_\_

NAME \_\_\_\_\_

### IMMUNIZATIONS

Childhood Shots Given:

DPT _____	Mumps _____
Measles _____	Rubella _____
Polio _____	Smallpox _____
Tetanus Booster _____	Date _____
Pneumonia Vaccine _____	Date _____
Hepatitis B (series of three shots) _____	Date _____
Gardasil Vaccine _____	Date _____
Other _____	Date _____

### IV. LIFESTYLE HISTORY

Smoker

Current       Ex-Smoker       Nonsmoker       Chewing Tobacco

If a smoker, number of packs (pipes, cigars) per day \_\_\_\_\_

How long have you smoked? \_\_\_\_\_

If ex-smoker, when did you quit? \_\_\_\_\_

Alcohol

Do you drink alcohol?       Yes       No

What do you usually drink? \_\_\_\_\_

How much? \_\_\_\_\_ How often? \_\_\_\_\_

Do you now have, or have you ever had an alcohol problem? \_\_\_\_\_

Drugs/Chemicals/Prescription Drugs

Do you use illicit drugs/chemicals?       Yes       No

Do you overuse any prescription drugs?       Yes       No

If so what do you use regularly? \_\_\_\_\_ How often? \_\_\_\_\_

What do you use occasionally? \_\_\_\_\_ How often? \_\_\_\_\_

Do you now have, or have you ever been addicted to any drugs? \_\_\_\_\_

Exercise

Do you exercise regularly? \_\_\_\_\_

What activity? \_\_\_\_\_

How often? \_\_\_\_\_

How long is each session? \_\_\_\_\_

Diet

Do you have any dietary concerns? \_\_\_\_\_

List any foods you avoid in your diet. \_\_\_\_\_

Usual number of meals per day \_\_\_\_\_

Number of times per week you eat "fast foods" \_\_\_\_\_

Caffeine? \_\_\_\_\_ How much \_\_\_\_\_

Work

Current occupation \_\_\_\_\_

Have you had any work related illnesses or injuries? \_\_\_\_\_

Do you have a history of exposure to radiation (x-ray) or toxic chemicals or substances?

Yes       No

Do you have excessive work related stress? If so explain.

\_\_\_\_\_  
\_\_\_\_\_

## V. REVIEW OF SYSTEMS

In the past have you been diagnosed as having any of the following conditions?

### Heart/Blood

- High blood pressure
- Hardening of the arteries
- Heart attack
- Stroke or "TIA"
- Heart Murmur
- Angina
- Congestive heart failure
- High Cholesterol or Triglycerides
- Varicose veins
- Phlebitis (blood clots)
- Pulmonary Embolism
- Anemia
- Bleeding Disorders

### Muscle/Joints/Bones

- Back or neck strain
- Osteo Arthritis
- Rheumatoid arthritis
- Lupus
- Osteopenia or Osteoporosis

### Endocrine/Glandular

- Hyperthyroidism (over active thyroid)
- Hypothyroidism (low thyroid)
- Diabetes
- Pernicious anemia
- Iron deficiency anemia

### Mental/Emotional

- Depression
- Bulimia or Anorexia
- Panic Attacks
- Anxiety Disorder
- PTSD (Post Traumatic Stress Disorder)
- Suicide Attempt

### Digestive

- Peptic ulcer (gastric or duodenal)
- Gastritis/Esophagitis
- Giardia or other parasite
- Intestinal polyps
- Malabsorption
- Diverticulosis
- Diverticulitis
- Irritable bowel (spastic colon)
- Reflux or GERD
- Hepatitis A, B or C
- Crohn's colitis
- Hemorrhoids

### Nervous System

- Migraine headaches
- Cluster headaches
- Tension headaches
- Multiple Sclerosis

### Eyes, Ears, Nose & Throat

- Cataracts
- Glaucoma
- Sinusitis
- Menieres Disease
- Nasal polyps
- Allergic rhinitis
- Tonsillitis
- Gum disease

### Respiratory/Lungs

- Emphysema
- Chronic bronchitis
- Pneumonia
- Asthma
- T.B. Tuberculosis

### Cancer

- Cancer
- Type(s) \_\_\_\_\_

### Kidneys

- Cystitis (bladder infection)
- Pyelonephritis (kidney infection)
- Kidney stones
- Incontinence (Urine leakage)

### Reproductive

- Fibrocystic breast disease
- Galactorrhea (breast discharge)
- Pelvic inflammatory disease
- Abnormal pap smear
- Uterine Fibroids
- Dysmenorrhea (Painful Cramps)
- Vaginitis
- Ovarian cysts or tumors
- PMS or PMDD
- Endometriosis
- Ulcerative colitis     HIV or AIDs
- STDs Sexually Transmitted Diseases
- Genital Herpes

NAME \_\_\_\_\_

**Other**

- Abnormal x-ray findings  \_\_\_\_\_
- Chronic Fatigue syndrome  \_\_\_\_\_
- Fibromyalgia  \_\_\_\_\_

**Presently or in the recent past, have you had any of the following symptoms:**

- Recurrent headaches
- Fever (unexplained)
- Chills
- Generalized fatigue
- Generalized body aches
- Generalized weakness
- Neck stiffness
  
- Coughing up blood
- Shortness of breath on exertion
- Shortness of breath while laying down
  
- Nausea
- Diarrhea
- Constipation
- Abdominal cramping pain
- Blood in or on stool
- Rectal bleeding
- Change in bowel habits
  
- Easy bruising or bleeding
- Change in skin or moles
- Lumps in neck, underarms or groin
- Changes in hair
  
- Other**
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
  
- Weight loss # of pounds lost \_\_\_\_\_
- Weight gain # of pounds gained \_\_\_\_\_
- Change in appetite
  
- Change in vision
- Double vision
- Change in hearing
- Ringing in ears
- Frequent nosebleeds
- Recurrent sinus infection
- Recurrent gum or tooth infections
- Recurrent sore throats
- Hoarseness
- Chronic cough
- Constant sinus drainage
- Trouble swallowing
- Swollen glands
  
- Blood in urine
- Frequent or urgent urination
- Painful urination
- Change in urinary habits
- Change in sexual desire
- Vaginal discharge or odor
- Change in menstrual periods
- Breast pain
- Nipple discharge
- Pain with Sexual Activity
- Breast lumps
- Night Sweats/Hot Flashes
- Depression
- Trouble sleeping
- Nervousness, panic
- Mood swings
- Loss of memory
- Difficulty regulating body temperature

NAME \_\_\_\_\_

## VI. HEALTH MAINTENANCE

Date of last physical/annual exam \_\_\_\_\_  
Doctor/Clinic \_\_\_\_\_  
Date of last Pap smear \_\_\_\_\_  
Date of last Cholesterol level \_\_\_\_\_  
Date of last EKG \_\_\_\_\_  
Date of last Chest X-Ray \_\_\_\_\_  
Date of last complete blood tests \_\_\_\_\_  
Date of last Thyroid level \_\_\_\_\_  
Date of last Sigmoidoscopy or Colonoscopy \_\_\_\_\_  
Date of last Bone Density Test \_\_\_\_\_  
Date of last Mammogram \_\_\_\_\_

## VII. Family History

Mother:

Age (if living) \_\_\_\_\_ Age (at death) \_\_\_\_\_ Cause of death \_\_\_\_\_  
List any medical problems she has or had

\_\_\_\_\_

\_\_\_\_\_

Father:

Age (if living) \_\_\_\_\_ Age (at death) \_\_\_\_\_ Cause of death \_\_\_\_\_  
List any medical problems he has or had

\_\_\_\_\_

\_\_\_\_\_

Siblings: Males \_\_\_\_\_ Females \_\_\_\_\_  
Ages (if living) \_\_\_\_\_ Ages (at death) \_\_\_\_\_ Cause/s of death \_\_\_\_\_  
List any medical problems he or she has or had (use the back of the sheet if needed)

\_\_\_\_\_

\_\_\_\_\_

**Any other blood relatives with:**

**Relationship**

- |  |       |
|--|-------|
| <input type="checkbox"/> Diabetes            | _____ |
| <input type="checkbox"/> High blood pressure | _____ |
| <input type="checkbox"/> High cholesterol    | _____ |
| <input type="checkbox"/> Heart Disease       | _____ |
| <input type="checkbox"/> Strokes             | _____ |
| <input type="checkbox"/> Breast cancer       | _____ |
| <input type="checkbox"/> Ovarian cancer      | _____ |
| <input type="checkbox"/> Bowel Cancer        | _____ |
| <input type="checkbox"/> Other Cancer        | _____ |
| <input type="checkbox"/> Osteoporosis        | _____ |
| <input type="checkbox"/> Alzheimers/Dementia | _____ |
| <input type="checkbox"/> Thyroid Problem     | _____ |

NAME \_\_\_\_\_

**VIII. Comments**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date