Centura Health Physician Group

Centura Health

OB/GYN Supplement
PG-2002 rev. 01/18

Name: _____ DOB: _____/_____/_____

Chief Complaint (reason for visit): _____

Method of Birth Control (if applicable): _____

Menstrual Periods First day of Last Menstrual Period: _____ ☐ N/A Reason: _____

Do you have regular periods? ☐ Yes ☐ No Cycle length (days between periods): _____ Length of bleed: _____ days

Bleeding is: ☐ Light ☐ Moderate ☐ Heavy Bleeding between periods? ☐ Yes ☐ No Pain with period is (0-10): _____

Pregnancy History:

___Total Pregnancies ___Term Birth ___Preterm Birth ___Miscarriages ___Multiples ___Ectopic ___Abortions ___Living Children

#	Month/Day/Year	Gender	Weight	Weeks Pregnant	Delivery Type	Anesthesia	Complications/Notes
1							
2							
3							
4							
5							
6							

Pap Smears Date of Last Pap: _____ Was it normal? ☐ Yes ☐ No

Have you ever had an abnormal Pap? ☐ Yes Date: _____ ☐ No

If yes, what was the treatment? ☐ Colposcopy ☐ Cone Biopsy ☐ Observation ☐ LEEP ☐ Cryosurgery

Menopause Symptoms ☐ Hot Flashes ☐ Irritability ☐ Vaginal Dryness ☐ Other: _____

Have you had any vaginal bleeding since menopause? ☐ Yes ☐ No

Are you currently taking hormone replacement therapy? ☐ Yes ☐ No

Previous hormone replacement therapy? ☐ Yes ☐ No

Breast Health Date of last mammogram: _____ ☐ Never ☐ Other Breast Imaging: _____

How often do you perform self-breast exams? ☐ Never ☐ Monthly ☐ Less than Monthly ☐ Other: _____

History of breast problems? ☐ Yes ☐ No Current: Masses/Lumps, Pain, Skin Changes/Redness? ☐ Yes ☐ No

Colon Health: Date of last colonoscopy: _____

History

Are you currently sexually active? ☐ Yes ☐ No Recurrent vaginal infections? ☐ Yes ☐ No

Have you ever had: ☐ Chlamydia ☐ Gonorrhea ☐ Hepatitis ☐ Herpes ☐ HIV ☐ Human Papilloma virus (HPV) ☐ Syphilis

Have you had the Human Papillomavirus (HPV) vaccine (i.e. Gardasil)? ☐ Yes ☐ No

Did you take the full course? ☐ Yes ☐ No ☐ Uncertain Have you ever used fertility medications? ☐ Yes ☐ No

Please list any medical, surgical, social or family history changes since your last visit: _____

_____

_____

Signature: _____ Date: _____

(Patient or Authorized Representative)