

# GENESIS WOMEN'S CENTER

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## PATIENT HISTORY

Name  Date

Address  Email

City  State  Zip Code

Home Phone  Work Phone  Cell Phone

Date of Birth  Age  Social Security # --

Occupation  Race

Employer  Address

City  State  Zip Code

Marital Status: Single Married Divorced Separated Widowed

If Married, give the following information about your spouse:

Name  Date of Birth

Occupation  Employer

Business Phone  Social Security # --

In case of emergency contact:

Name  Relationship  Phone

Family Physician  Phone

Dentist  Phone

Whom may we thank for referring you? Name  Phone

Who is responsible for payment? Name  Phone

I will be paying today by: Cash Check Credit/Debit Card

I understand and agree that (regardless of insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I certify the information contained on this form is true and correct to the best of my knowledge. I will notify you of any changes in my health status or above information.

*Please Print, then Sign and bring this document in to our office.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature (if minor) \_\_\_\_\_

Are you allergic to any medication? Yes No If yes, list below:

[Empty text box for listing allergies]

Please list any medications you are currently taking:

[Empty text box for listing medications]

Do you smoke cigarettes? Yes No

If yes, how many per day? Less than 1 pack 1 pack More than 1 pack

Do you use marijuana or other Recreational Drugs? Yes No

If yes, what kind? [ ] How often? [ ]

Do you drink alcohol-containing beverages? Yes No

If yes, how many times per week and how much each time? [ ]

**Menstrual History**

Age at onset [ ] Interval (Days) [ ] Duration (Days) [ ]

Amount: Heavy Moderate Light

Date of last Menstrual Period (LMP) [ ] Was it normal? Yes No

If no, describe:

[Empty text box for describing menstrual history]

	<b>Yes</b>	<b>No</b>
Do you have flooding or frequent heavy clots with your period?	<input type="radio"/>	<input type="radio"/>
Do you have any bleeding between periods?	<input type="radio"/>	<input type="radio"/>
Do you have any bleeding after intercourse?	<input type="radio"/>	<input type="radio"/>
Do you have bad cramps with your period?	<input type="radio"/>	<input type="radio"/>
Do you have an annoying vaginal discharge?	<input type="radio"/>	<input type="radio"/>
Do you have any vaginal itching?	<input type="radio"/>	<input type="radio"/>
Do you have any pain with intercourse?	<input type="radio"/>	<input type="radio"/>
Do you have any sexual problems which you would like to discuss?	<input type="radio"/>	<input type="radio"/>
Are you having any problems with urination?	<input type="radio"/>	<input type="radio"/>

If yes, explain:

[Empty text box for explaining urination problems]

Do you do breast self-examination? Yes No

Have you ever had a mammogram? Yes No

If yes, date of last exam: [ ]

Have you ever had a Pap smear? Yes No

If yes, date of last exam: [ ]

Have you ever had an abnormal Pap smear? Yes No

If yes, explain:

[Empty text box for explaining abnormal Pap smear]

Have you ever had any sexually transmitted diseases? Yes No

If yes, what kind:

[Empty text box for describing STDs]

Do you have any of the following: Hot flashes Vaginal dryness

Do you have any current gynecologic problems that you wish to discuss?

[Empty text box for discussing gynecologic problems]

Method of Birth Control: Pill Condoms IUD Sponge Spermicides Diaphragm Tubal Ligation Vasectomy Other (describe) [ ]

### OBSTETRIC HISTORY

Specify the number of: Full-Term pregnancies:  Premature Deliveries:   
 Abortions: Spontaneous(Miscarriages):  Induced:   
 Living children:  Deliveries involving multiple births:

Did any maternal complications occur during any of these previous pregnancies or deliveries?  
 Yes  No If yes, give details

Details of previous pregnancies. List from youngest to oldest:

Year	Length of pregnancy in weeks	C-Sect (C) or Vaginal (V)	Born Alive (A) Born Dead (D)	Birth Weight
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Were there any complication in any of the infants during pregnancy or delivery?  Yes  No  
 If yes, give details:

Demographic Data on living children. List from youngest to oldest:

Name	Date of Birth	Sex	Place of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

### MEDICAL HISTORY

Do you have any medical condition for which you are under a doctor's care?  Yes  No  
 If yes, give details:

### SURGICAL HISTORY

Have you ever had surgery?  Yes  No  
 If yes, give details (operation and approx. date) below:  
  
 If you had any complications, including blood transfusions, please explain:

**FAMILY HISTORY**

Check any of the following conditions that have occurred in parents, aunts/uncles, brothers/sisters, or children:

- Tuberculosis    Hypertension    Heart Disease    Diabetes    Mental Illness
- Epilepsy    Cancer    Multiple Births    Birth Defects

If any have been checked, give details:

**REVIEW OF SYSTEMS**

Do you have any problem with the following:

	<b>Yes</b>	<b>No</b>
Heart	<input type="radio"/>	<input type="radio"/>
Lungs	<input type="radio"/>	<input type="radio"/>
Digestive tract	<input type="radio"/>	<input type="radio"/>
Bones or Joints	<input type="radio"/>	<input type="radio"/>
Thyroid or other Glands	<input type="radio"/>	<input type="radio"/>
Kidneys	<input type="radio"/>	<input type="radio"/>
Nervous System	<input type="radio"/>	<input type="radio"/>

If any of the above have been checked, or you have any questions or subjects you would like to discuss, use the box below.