

What is the reason for your visit today? If it is a problem, please describe the symptoms & be specific: _____

OB HISTORY

- 1. How many times have you been pregnant?
- 2. How many miscarriages have you had?
- 3. How many abortions have you had?
- 4. Have you had any Tubal/Ectopic pregnancies?
- 5. How many vaginal deliveries have you had?.....
- 6. How many Cesarean Sections have you had?.....
- 7. Have you had any premature deliveries?
- 8. Have you had any babies weighing less than 5 lb 8 oz at birth?
- 9. How many full term deliveries?
- 10. Have you had any twin births?.....
- 11. Did you have any complications with your pregnancies? YES NO
If yes, list: _____

GYN HISTORY

- 1. Are you sexually active? YES NO
- 1a. Have you been sexually active? YES NO
- 2. Do you have pain with intercourse? YES NO
- 3. What type of contraception are you currently using? (CIRCLE BELOW)
Pills Tubal Ligation Condoms Withdrawal Depo Provera IUD
Foam Vasectomy Diaphragm Implants Other _____
- 4. What type of contraception have you used in the past? (CIRCLE BELOW)
Pills Tubal Ligation Condoms Withdrawal Depo Provera IUD
Foam Vasectomy Diaphragm Implants Other _____
- 5. Are you having any problems with your method of Birth Control? YES NO
- 6. Have you ever had any vaginal, cervical and/or tubal infection? YES NO
If yes, please check below:
 Yeast Gardnerella Syphilis Condyloma Bacterial Vaginitis PID
 Herpes Trichomonas Chlamydia Gonorrhea Warts Other _____
- 7. Date of last pap smear? _____
- 8. Have you ever had an abnormal pap smear? YES NO
If yes, how was it treated? Please check below:
 Repeated Pap Smear Colposcopy Laser Surgery Cone Biopsy
 Cryosurgery (freezing) Hysterectomy Loop Excision
- 9. Do you have trouble leaking urine? YES NO

10. Do you have any breast lumps, tenderness or discharge? YES NO
- 10a. Have you had a mammogram? YES NO
 If yes, was it normal? YES NO
 Date of last mammogram _____
11. Do you do breast self exams? YES NO
12. Do you have PMS symptoms? YES NO
 If yes, any treatment? _____
13. Do you have any hot flashes or menopausal symptoms? YES NO
14. Do you have any uterine anomalies? YES NO
15. Do you have a history of infertility? YES NO
16. Do you have a history of DES exposure? YES NO

MENSTRUAL HISTORY

1. If you no longer have periods, please state reason: _____
2. First day of last period: _____
3. How many days does your period last? _____
4. Are your periods regular? YES NO
5. How many days from the start of one period to the start of the next period? _____
6. Has the flow changed in any way? _____ If so, how? _____
7. Do you have any bleeding between periods? YES NO
8. Do you have any cramping with your periods? YES NO
 If yes, circle one: mild moderate severe
9. Medicine taken for cramps? _____

SOCIAL HISTORY

1. Do you smoke cigarettes? YES NO
 If yes, # per day? _____ Number of years? _____
2. Do you use street drugs? YES NO
3. Do you drink alcohol? YES NO
 If yes, how much per day? _____

PAST MEDICAL HISTORY

- 1. Do you have diabetes? YES NO
- 2. Do you have/had hypertension? YES NO
- 3. Do you have heart disease? YES NO
- 4. Do you have a heart murmur? YES NO
- 5. Do you have/had kidney disease? YES NO
- 6. Have you ever been treated for psychiatric problems? YES NO
- 7. Have you ever had rheumatic fever? YES NO
- 8. Do you have mitral valve prolapse? YES NO
- 9. Have you ever had a urinary tract infection? YES NO
- 10. Have you ever had hepatitis/liver disease? YES NO
- 11. Have you ever had varicosities/phlebitis? YES NO
- 12. Do you have any thyroid problems? YES NO
- 13. Have you had any major accidents? YES NO
- 14. Have you ever had any blood transfusions? YES NO
- 15. Do you have asthma/lung disease? YES NO
- 16. Do you have any Drug Allergies? YES NO

If yes, please list: _____

17. Please list any GYN surgeries:

18. Please list any other operations/hospitalizations (include year & reason):

19. Have you had any anesthesia complications? YES NO

If yes, please list: _____

20. Have you ever been anemic? YES NO

21. Do you have an Internist or Family doctor? YES NO

Please list name, phone number:

22. Are you currently on any medications? YES NO

If yes, please list with dosage: _____

23. Have you had your cholesterol checked? YES NO

If yes, date last checked: _____

Was it normal? YES NO

24. Do you have Arthritis? YES NO

If yes, what type? _____

25. Do you have Lupus, Scleroderma or similar diseases? YES NO

If yes, please describe: _____

FAMILY HISTORY

- | | | |
|---|------------------------------|-----------------------------|
| 1. Do you have a family history of breast cancer?
If yes, whom? _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Do you have a family history of colon cancer?
If yes, whom? _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Do you have a family history of ovarian cancer?
If yes, whom? _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Do you have a family history of osteoporosis?
If yes, whom? _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Do you have a family history of diabetes?
If yes, whom? _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Do you have a family history of hypertension?
If yes, whom? _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Do you have a family history of heart disease?
If yes, whom? _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Do you have a family history of kidney disease?
If yes, whom? _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

PATIENT CONSENT TO LEAVE DETAILED MESSAGE/INFORMATION

Dear Patient

Dr. Byers requires our staff to obtain prior authorization to leave voice mail/messages for the patient. This policy is to protect the patient and also to protect our staff from violating the patient's confidentiality. If we do not have a signed consent form on file, the staff may leave only their name and a phone number on an answering machine asking you to call them back.

By completing the consent below, you hereby authorize the staff to call and leave their name, doctor's name, and additional information on an answering machine or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

I give my consent to Dr. Byers and/or staff to leave a message regarding treatment, test results or other necessary information.

- 1) On answering machine at home: _____
- 2) On voice mail at work: _____
- 3) On cell phone voice mail: _____

Please print phone number on lines

Patient's Signature

Date

I DO NOT consent to any messages being left on an answering machine other than caller's name and phone number.

Patient's Signature

Date

Thank You for choosing Dr. Byers as your Sottpelle certified doctor.

Please give the nature or your referral:

Person _____

Other _____

Please understand that the pellets cannot be removed after insertion.

Any questions please direct to Dr. Byers during your consult.

Thank You Again,
Byers Wellness Center

We must have all paperwork into the office before we can schedule any consultation or insert. This will help make your visit with us alot smoother.

Thank you for your cooperation.

We look forward to your visit with us.

Byers Wellness Center

770-387-3450