

NAME _____ DOB: ____/____/____ DATE ____/____/____

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PRIMARY CARE PHYSICIAN NAME: _____

REASON FOR VISIT: PLEASE LIST YOUR HEALTH CONCERNS, PROBLEMS, AND SYMPTOMS.

DRUG OR FOOD ALLERGIES? _____

IF YOU ARE ON MEDICATIONS PLEASE LIST THE NAMES AND DOSAGE OF THE MEDICATION.

ARE YOU CURRENTLY HAVING ANY OF THE FOLLOWING SYMPTOMS?

CONSTITUTIONAL		GENITOURINARY		LATE/MISSED MENSTRUAL PERIOD
	CHILLS		DYSMENORRHEA	URINARY RETENTION
	FATIGUE		DYSPAREUNIA	UTERINE CRAMPING
	FEVER		DYSURIA	FETAL MOVEMENT OF NORMAL FREQUENCY AND INTENSITY
	NIGHT SWEATS		GENITAL LESIONS	IRREGULAR PERIODS
	VICTIM – DOMESTIC VIOLENCE		HEMATURIA	PREGNANCY RELATED COMPLAINTS
	WEIGHT GAIN (UNINTENTIONAL)		HIGH RISK SEXUAL BEHAVIOR	POST OPERATIVE WOUND – NORMAL FINDINGS
	WEIGHT LOSS (UNINTENTIONAL)		HISTORY OF FREQUENT UTI'S	PSYCHIATRIC
INTEGUMENTARY/BREAST			HISTORY OF RECURRENT BACTERIAL VAGINOSIS	ANXIETY
	WART(S)		IRREGULAR MENSTRUAL CYCLE	DEPRESSION
	BREAST MASS		MONORRHAGIA	MOOD SWINGS
	BREAST SKIN CHANGES		NOCTURIA	PMS (Premenstrual Tension)
	BREAST TENDERNESS		POLYURIA	RECREATIONAL DRUG USE
	NIPPLE DISCHARGE		POST-COITAL VAGINAL BLEEDING	SLEEP DISTURBANCE
	SELF BREAST EXAMS?		POST-MENOPAUSAL BLEEDING	SUICIDAL THOUGHTS
ENDOCRINE			HISTORY OF RAPE	PREGNANCY – COMMON COMPLAINTS
	HIRSUTISM		SEXUAL ABUSE	BRAXTON-HICKS CONTRACTIONS
	HOT FLASHES		URINARY INCONTINENCE	ROUND LIGAMENT PAIN
	INFERTILITY		VAGINAL DISCHARGE	PELVIC PRESSURE
	SWEATING, EXCESSIVE		VAGINAL ITCHING	UTERINE CRAMPING
OTHER: _____			PELVIC PAIN	CONTRACTIONS
_____			ABNORMAL VAGINAL BLEEDING	SWELLING IN FEET

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CONTRACEPTION METHODS

WHAT TYPE OF BIRTH CONTROL METHOD(S) ARE YOU CURRENTLY USING OR HAVE USED IN THE PAST? (CIRCLE ALL THAT APPLY)					
BIRTH CONTROL PILLS	CONDOMS	DEPO PROVERA	IUD	TUBAL LIGATION	PARTNER VASECTOMY

HAVE YOU HAD THE FOLLOWING COMPLICATIONS WITH YOUR PREGNANCY (IES)

PIH PREGNANCY INDUCED HYPERTENSION	YES OR NO	PRETERM LABOR	YES OR NO
TOXEMIA	YES OR NO	GESTATIONAL DIABETES	YES OR NO
IUGR	YES OR NO	HIGH BLOOD PRESSURE	YES OR NO

LIST ANY OTHER COMPLICATIONS YOU HAVE HAD DURING PAST PREGNANCIES _____

**HAVE YOU EVER HAD SURGERY ON THE FOLLOWING?
PLEASE SPECIFY.**

APPENDIX (DATE) ___/___/___	BREASTS (DATE) ___/___/___ LEFT OR RIGHT BREAST TYPE OF SURGERY: _____
C-SECTION (DATES) ___/___/___	DENTAL (DATE) ___/___/___ TYPE OF SURGERY: _____
GALL BLADDER (DATE) ___/___/___	HEMORRHOIDS (DATE) ___/___/___
HERNIA (DATE) ___/___/___	HYSTERECTOMY (DATE) ___/___/___
LAPAROSCOPY (DATE) ___/___/___	ORTHOPEDIC (DATE) ___/___/___
OVARIES (DATE) ___/___/___	STOMACH / INTESTINES (DATE) ___/___/___
THYROID (DATE) ___/___/___	TONSILS (DATE) ___/___/___
TUBAL LIGATION (DATE) ___/___/___	VARICOSE VEINS (DATE) ___/___/___
OTHER: _____ (DATES) ___/___/___	OTHER: _____ (DATE) ___/___/___

SOCIAL HISTORY

MARITAL STATUS (CIRCLE ONE): MARRIED SINGLE DIVORCED SEPARATED WIDOWED
PLACE OF EMPLOYMENT: _____ OCCUPATION _____

NUMBER OF CHILDREN: _____ AGES: _____

DO YOU EXERCISE REGULARLY? YES OR NO TYPE: _____ HOW OFTEN? _____

TOBACCO / ALCOHOL / SUPPLEMENTS

DO YOU CURRENTLY SMOKE? YES OR NO DID YOU RECENTLY QUIT SMOKING? _____ IF SO, WHEN? _____

IF YOU DO SMOKE HOW MUCH: DAILY _____ WEEKLY _____

DO YOU CURRENTLY DRINK ALCOHOL? YES OR NO

IF YOU DO DRINK, HOW MUCH: DAILY _____ WEEKLY _____ TYPE: BEER? ____ WINE? ____ LIQUOR? ____

DO YOU CURRENTLY DRINK CAFFEINE? YES OR NO IF YOU DO DRINK, HOW MUCH: DAILY _____ WEEKLY _____

DO YOU CURRENTLY TAKE SUPPLEMENTS? YES OR NO

(SPECIFY): _____

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SUBSTANCE ABUSE HISTORY (CIRCLE ALL THAT APPLY)

MARIJUANA	YES OR NO	OTHER: _____ _____ _____
COCAINE	YES OR NO	
METHAMPHETAMINES	YES OR NO	

MENTAL HISTORY (CIRCLE ALL THAT APPLY)

ANXIETY	YES OR NO	EATING DISORDERS	YES OR NO
DEPRESSION	YES OR NO	OBSESSIVE COMPULSIVE DISORDERS	YES OR NO
SCHIZOPHRENIA	YES OR NO	SEXUAL DISORDERS	YES OR NO
SLEEP DISORDERS	YES OR NO	OTHER	
Are you currently receiving or have you in the past received treatment from a psychiatrist, counselor, or psychologist?		YES OR NO	
Are you currently taking or have you in the past taken medications for a psychiatric illness?		YES OR NO	

COMMUNIBACLE DISEASES (CIRCLE ALL THAT APPLY)

CHLAMYDIA	YES OR NO	GONORRHEA	YES OR NO
CONDYLOMA (GENITAL WARTS)	YES OR NO	GENITAL HERPES	YES OR NO
HIV	YES OR NO	HIGH RISK HPV	YES OR NO
SYPHILIS	YES OR NO	PELVIC INFLAMMATORY DISEASE	YES OR NO
HEPATITIS A,B OR C	YES OR NO	LYME DISEASE	YES OR NO
MEASLES	YES OR NO	MUMPS	YES OR NO
RUBELLA	YES OR NO	OTHER	

