INOVA®

Name: ______________________ Date of Birth: ____________

Date of Visit: ____________

Reason for Visit: ______________________

Allergies: ______________________

Past Medical History (list all prior medical diagnoses)

______________________ ______________________

______________________ ______________________

______________________ ______________________

Past Surgical History (list all surgeries and dates)

Surgery	Date	Surgery	Date

Significant Medical Conditions in Your Family

Condition	Family Member	Condition	Family Member

Medications (include over-the-counter medications)

Medication	Dose	Frequency

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? ____________

Do you vape? ☐ Yes ☐ No Do you use smokeless tobacco (ex. chew, snuff)? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? ____________

Do you currently or have you ever used illicit drugs? ☐ Yes ☐ No If yes, please list: ____________

Do you exercise? ☐ Yes ☐ No If yes, how often? ____________

Age at first menstrual period:	First day of last menstrual period:
Number of days between menstrual periods:	Number of days menstrual period lasts:
Are you having any menstrual problems? ☐ Yes ☐ No If yes, describe:	
Are your periods: ☐ Regular ☐ Irregular	**Number of pads or tampons/day:**
Flow: ☐ Light ☐ Moderate ☐ Heavy	**Cramps:** ☐ Mild ☐ Moderate ☐ Severe

Are you menopausal? ☐ Yes ☐ No If yes, age at which you started menopause: ____________

If you are menopausal, are you having any vaginal bleeding? ☐ Yes ☐ No If yes, describe: ____________

When was your last Pap Test? ____________ Was it normal? ☐ Yes ☐ No

Have you ever had an abnormal Pap Test? ☐ Yes ☐ No If yes, when? ____________

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ____________

Date of Birth: ____________ Medical Record # ____________

Gender: ❑ Male ❑ Female

Inova Medical Group

OB/GYN

Medical Condition & History

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

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2PSMHX

Date of last: Mammogram: ______________ DEXA (bone density scan): ______________
Colonoscopy: ______________ Tdap/Tetanus vaccine: ______________

Have you received the Human Papillomavirus (HPV) vaccine? ☐ Yes ☐ No

What type(s) of birth control have you used in the past? ☐ Intrauterine Device (IUD) ☐ Oral Contraceptives ☐ Depo Provera ☐ Other ______________________________

Current Contraception: ______________________ Do your partners use condoms? ☐ Yes ☐ No

Are you currently sexually active? ☐ Yes ☐ No Are your partners: ☐ Male ☐ Female ☐ Both

Number of sexual partners over your lifetime: ________ Number of times you have sex per month: ________

Do you want to be tested for sexually transmitted diseases (STDs)? ☐ Yes ☐ No

Have you ever had an sexually transmitted disease (STD)? ☐ Yes ☐ No

If yes, check any of the STDs which you have had: ☐ Chlamydia ☐ Gonorrhea ☐ Venereal Warts ☐ Genital Herpes ☐ HPV ☐ Human Immunodeficiency Virus (HIV) ☐ Other: ______________________

Pregnancies

Pregnancy Date	Type of Delivery (vaginal or c-section)	Complications	Pregnancy Dates	Type of Delivery (vaginal or c-section)	Complications

Number of:	Miscarriages:	Terminations:	Living Children:

Current Medical Conditions (please check all that you are currently experiencing):

☐ Blood in stool
☐ Blood in urine
☐ Breast pain
☐ Chest pain
☐ Constipation
☐ Cough
☐ Decreased sexual drive
☐ Diarrhea
☐ Difficulty concentrating
☐ Dizzy spells/fainting
☐ Domestic violence
☐ Excess body/facial hair
☐ Fever
☐ Frequent bruising
☐ Hair loss
☐ Headaches
☐ Heartburn/indigestion
☐ Heat/cold intolerance
☐ Hot flashes/night sweats
☐ Irregular heartbeat
☐ Nausea
☐ Pain or bleeding with sex
☐ Pelvic pain
☐ Premenstrual symptoms
☐ Severe joint/muscle pain
☐ Skin lesions
☐ Trouble breathing
☐ Trouble sleeping
☐ Trouble with balance
☐ Unexplained weight change
☐ Unusual fatigue
☐ Urination-frequency increase
☐ Urination-incontinence
☐ Urination-pain
☐ Vaginal discharge/odor
☐ Vaginal dryness
☐ Vulvar itching/rash
☐ Victim of sexual abuse
☐ Vomiting
☐ Other: ____________________
____

☐ Check here if more space is needed. Continue on back of page.

My signature verifies that the information provided is correct to the best of my knowledge.

____ ______________ ___________
Patient or Designated Decision Maker (signature) Date Time

____ ______________________
If Designated Decision Maker (print name) Relationship

Reviewed by Physician (signature): ____________________________ Date: ____________ Time: __________

Physician (print name): ______________________________________

Interpreter Information (To be completed by Inova staff, if applicable)**:**
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) ______________________
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

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OB/GYN
Medical Condition & History

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