Leslie S. Welborne, M.D.

Centennial OB/GYN, P.A.

Melissa Bailey, M.D.
Alisa Ward, M.D.

Name _____ DOB _____ Marital Status _____ Date _____

Reason for Visit

_____

_____

Allergies to Medications

If yes, please name medicine and describe type of reaction

_____

_____

Medications and Supplements

Please give name and dosage

_____

_____

_____

Pregnancy History

Total Pregnancies___ Full Term___ Pre-term___ Miscarriage___ Abortion___ Ectopic__

Date	Length of Pregnancy	Type of Delivery	Sex	Weight	Living	Complications

Menstrual History

At what age did you start having menstrual periods? _____

Number of days between first day of one and first day of next period? _____

Length of period? _____ Regular or Irregular _____

Would you call your periods ( ) light ( ) medium ( ) heavy ( ) clots

When was the first day of your last menstrual period? _____ Do you have cramps?_____

Was it a normal period? _____ If not, when was the last normal one? _____

Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods/cramps? __ Y __ N

Contraception

What is your current form of birth control?

Abstinence Birth Control pill Hysterectomy IUD Menopause Tubal ligation Vasectomy
Nuvaring Patch Depoprovera Rhythm Condoms Nexplanon Nothing

How long have you been using your current form of birth control? (please check one)

__ 2 yrs or less __ 3-5 yrs __ 6-10 yrs __ over 10 yrs

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When are you planning to have another child? (please check one)

__ within 1-2 yrs __ within 5-10 yrs __ my family is complete

If menopausal, at what age did your periods stop? _____

Date of last pap smear? _____ Normal/Abnormal? Have you had an abnormal pap smear? _____

If yes, please give dates, type (ASCUS, HPV, CIN I, etc.) and treatments (Colposcopy, Cryo, Cone Biopsy, LEEP)

_____

Date of last mammogram? _____ Normal/Abnormal? Have you had an abnormal mammogram? _____

If yes, please give dates and explain: _____

Date of last Bone densitometry? _____ Normal / Osteopenia / Osteoporosis

Past Medical History

Please check if you currently have or have had a history of any of the following:

YES	NO		YES	NO	
( )	( )	Reflux/Heartburn	( )	( )	Fibromyalgia
( )	( )	Spastic Colon/Irritable Bowel	( )	( )	Arthritis-Rheumatoid/Osteo
( )	( )	Hepatitis	( )	( )	Diabetes
( )	( )	Ulcers	( )	( )	Thyroid Problems
( )	( )	Hypertension	( )	( )	Osteoporosis
( )	( )	Heart Disease	( )	( )	Nervous Disorder/Depression
( )	( )	Angina	( )	( )	Rheumatic Fever
( )	( )	Heart Murmur	( )	( )	Migraines
( )	( )	Hypercholesterolemia	( )	( )	Dementia
( )	( )	Blood Clotting Problems/DVT	( )	( )	Stroke/TIA
( )	( )	Asthma	( )	( )	Epilepsy
( )	( )	Sleep apnea	( )	( )	Anemia
( )	( )	Tuberculosis	( )	( )	Sickle Cell Disease/Trait
( )	( )	Pneumonia	( )	( )	Allergies
( )	( )	Emphysema	( )	( )	Eczema
( )	( )	Kidney/Bladder Infections	( )	( )	Psoriasis
( )	( )	Kidney Stones	( )	( )	Cancer_____
( )	( )	Hospitalizations - If yes, please explain:			

_____

Is blood transfusion acceptable in an emergency?_____

Do you have an Advance Directive?_____

Past Surgical History

Dates: Procedure:

_____

_____

_____

_____

_____

Immunizations (please list dates)

Tetanus: _____ HPV: _____ Flu: _____

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Who is your Primary Care Physician?

_____

Family History

YES	NO		YES	NO	
( )	( )	Breast Cancer	( )	( )	Diabetes
( )	( )	Ovarian Cancer	( )	( )	Thyroid Disorder
( )	( )	Uterine Cancer	( )	( )	Osteoporosis
( )	( )	Colon Cancer	( )	( )	Epilepsy/Seizures
( )	( )	Heart Disease	( )	( )	Stroke
( )	( )	Hypercholesterolemia	( )	( )	Depression/Bipolar/Schizophrenia
( )	( )	Hypertension	( )	( )	Birth Defects
( )	( )	DVT/Pulmonary Embolus	( )	( )	Other

If yes, please explain

_____

Social History

Employer/Occupation _____ Marital Status_____

Exercise Type/Frequency_____ Education Level_____

Smoking ___cigs/day Vaping___ Alcohol __drinks/wk Caffeine ___servings/day Illicit Drugs_____

Have you ever had a sexually transmitted disease? _____

Type/dates_____

Do you feel safe in your current relationship?_____

Review of Symptoms: (Circle current symptoms)

GENERAL - Fatigue Fever Weight gain Weight loss
CARDIOVASCULAR - Palpitations Chest pain
PULMONARY - Cough Shortness of breath
GASTROINTESTINAL - Bloating Constipation Diarrhea Hemorrhoids Bloody stools Nausea
URINARY - Pain with urination Blood in urine Frequency UTI's Incontinence
GENITAL - Irregular periods Painful intercourse History of sexual abuse Vaginal discharge Vaginal itching
MUSCULOSKELETAL - Back pain Joint pain
BREAST - Perform self breast exams-Regularly/Irregularly/Never Masses Tenderness Nipple discharge
SKIN - Rash Warts
NEUROLOGIC - Dizziness Headaches
BLOOD/LYMPHATIC - Easy bruising Bleeding easily History of blood transfusion Enlarged lymph nodes
ENDOCRINE - Hair loss Temperature intolerance Excessive hair growth
ALLERGIES - Seasonal allergies
PSYCHIATRIC - Anxiety Depression PMS Insomnia