HORIZONS
HEALTH & WELLNESS

Dear Patient,

Welcome to Dr. Aslami's OB/GYN office.

In order to help us prepare for a more efficient first office visit, we ask that you kindly fill out the following questionnaire to the best of your ability and forward it to our office prior to your scheduled visit either by fax or mail.

Primary care doctor: ______________________________Tel#__________________
Last visit: __________________________
Pharmacy Name & # _______________________________________

Medical History: Please list all major and minor medical problems you have: i.e. asthma, hypertension, etc. with approximate dates.

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Surgical History: Please list all major and minor surgeries with approximate dates:

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Past Hospitalizations: Please list dates and reasons for any hospitalizations.

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OB History: Please list all of your pregnancies including miscarriages, ectopic and abortions on this table.

Date	Type of delivery	Weight of baby	Name of baby	Hospital	Complications	Physician

GYN history:
How old were you when you started having periods? ___________
Are you still having regular periods? ______________.
If so, how often_____________
How long does your period last? __________________
Do you have extreme pain with your periods?___________.
If so, what do you take for the pain? _____________________________
Are you still sexually active? _________________
If so, any problems? Please describe ____
What are you currently using for contraception/birth control? _______________________

Do you have any urinary problems? ____

Medications
Please list all current medications with name, dosage, frequency and when they were started. Be sure to include any over the counter herbs and natural remedies also.

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Allergies to medications: (please list reaction)
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Preventive Care – date of last procedure if applicable:

Pap smear_______________________
Mammogram___________________
Colonoscopy ___________________
Bone Density ___________________

Vaccination History: (date of last)

Tetanus shot - ________________
Flu vaccine - ________________
Measles, mumps, rubella (MMR) vaccination - _______________
Have you had chicken pox? Y / N

Have you been vaccinated against:

Chicken pox - - - Y / N
Human papilloma virus (HPV) - Y / N
Hepatitis B - - - Y / N
(Vaccinations cont.)

Hepatitis A - - Y / N
Pneumonia - - Y / N

Caffeine – how many cups per day _____
Tobacco - Y / N – how many per day _____
Alcohol – how many per week ______
Exercise – how many days per week _________ - duration of workout ___________

Family history: (age, health status, history of any illnesses)

	Alive & well	Deceased	Age	Diagnoses (*eg. Hypertension, diabetes, heart disease, etc*
Mother				
Father				
Sisters				
Brothers				
Mat.G'Mother				
Mat.G'Father				
Pat.G'Mother				
Pat.G'Father				
Children				

Do any family members have a history of breast cancer? Y / N
Do any family members have a history of ovarian or uterine cancer? Y / N
Do any family members have a history of uterine cancer? Y / N
Do any family members have a history of colon cancer? Y / N
Do any family members have a history of blood clotting disorder? Y / N
If yes please explain relationship:

Social History:
What is your ethnic background: ____________________________
Marital status: ( ) married, ( ) single, ( ) divorced, ( ) widowed
Who lives in your home? ____
What kind of work do you do? __________________________________

Please list your hobbies/interests:
____
____

Are you currently suffering from any of the following symptoms? If yes, please describe.

Heat or cold intolerance - Y / N
Cough or shortness of breath - Y / N
Palpitations - - - Y / N
Dizziness - - - Y / N
Appetite/Weight changes - Y / N
Foot swelling - - Y / N

Abdominal pain - Y / N
Urinary problems - Y / N
Vomiting/nausea - Y / N
Diarrhea or constipation Y / N

Menopausal symptoms Y / N
Hot flashes - Y / N
Night sweats - Y / N
Irregular bleeding - Y / N
Mood swings - Y / N
Vaginal irritation/discharge Y / N
Sexual difficulties - Y / N
Pelvic pain - - Y / N
PMS symptoms - Y / N

Breast tenderness - Y / N

Back pain - - Y / N
Leg cramps - - Y / N

Anxiety - - Y / N
Depression - - Y / N
Sleep disorder - - Y / N
Headaches - - Y / N
Lumps/glands - - Y / N

Any other symptoms not noted above please list:

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Who may we thank for this referral?____