

Chico Nurse Midwifery Service, Inc.
1617 Esplanade, Chico, CA 95926 (530) 345-4471

General Information

Name (last, first): _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Marital Status : Single Married Separated Divorced Widowed Common-Law
 Primary Physician or Clinic: None _____
 Specialists I see : None _____

Present Symptoms

Main Reason for Visit: Annual Exam Menstrual Problems Hormonal Problems Vaginitis Birth Control
 Menopausal Problems Pelvic Pain Infertility Urinary Incontinence
 Referral from another physician I want screening for STD
 Other: _____

Gynecologic History

Age at first period: _____ Last period: _____ When was the period before that? _____
 How far apart are your cycles? _____ How many days do they last? _____
 Are you currently sexually active? Yes No Age at first intercourse: _____ # sexual partners: _____
 Symptoms associated with your period: Yes No
 Current form of birth control Yes No
 Previous forms of birth control Yes No
 Abnormal Pap smear Yes No
 Infertility Yes No
 Infections Yes No
 Do you use douches? Yes No
 Vaginal Discharge Yes No
 Cramps Yes No
 Pelvic Pain Yes No

Menopause Symptoms

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Describe Symptoms:

Obstetrical History (Please list all pregnancies, including miscarriages and ectopic pregnancies)

Year	Mode of Delivery	Anesthesia	Gestational Age	Gender	Weight	Complications

Medical/Surgical History

Please list all significant prior medical illnesses, hospitalizations and current medical problems for which you are under treatment.

Date:	

Name: _____

Medications

Please list all current medications – Prescription and non prescription, herbs, vitamins, etc.

Medication	Dosage	Frequency	Reason for medication, prescribing physician, pharmacy

Social History

Do you smoke cigarettes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How many cigarettes a day?	
If yes, are you interested in stopping smoking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> patches	<input type="checkbox"/> Wellbutrin
Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How many drinks per week?	<input type="checkbox"/> gum
Have you ever felt you ought to cut down on your drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> classes
Have people annoyed you by criticizing your drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Have you ever felt bad or guilty about your drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Do you use drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Which drugs?	
Do you use seatbelts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you exercise?	<input type="checkbox"/> Yes
				<input type="checkbox"/> No

Review of Systems – Please mark any problems

General / Constitutional	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Eyes/Glasses	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Ears/Nose/Throat/Mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart Disease/Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Respiratory/Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Gastrointestinal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Kidney/Gallbladder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Bone Fracture	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Skin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Neurological/Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Psychiatric/Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Breast	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Thyroid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hematology/Lymphatic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Allergic/Immunologic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Partner Violence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Family History (mark those that apply)

Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Bleeds easily	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cancer (type)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Colon polyps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Kidney/Gallbladder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Mental illness/Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Phlebitis / pulmonary embolus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Thyroid disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other inherited disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Details:

Signed: _____ Date: _____