Wellness Visit Form **Obstetrical Associates of St. Luke's**

Note: this is a confidential record and will be kept in your doctor's office. Information contained on this form will not be released without your permission.

Name: ____________________________________ Appointment Date:______________Date of Birth:__/__/__ Age:___

Who is your doctor in this office? ___________________ Who are you seeing today?___________________________

Pharmacy Name: ____________________ Pharmacy Number: _________________Preferred Lab: _________________

Chief Complaint/History of Present Illness

What is the reason for your visit? (Be as specific as possible)

____

____

____

Have you had any changes in surgical / medical / or family history since your last visit? Please be specific.

____

____

Medication and Allergies

Are you on any medications? Y N (if yes please list)	Do you have any allergies? Y N (If yes, list all)
_______________________ _______________________	___________________ _________________
_______________________ _______________________	___________________ _________________
_______________________ _______________________	___________________ _________________

Social History

Do you smoke? Y N How much?_______________ For how long?_______________

Do you drink alcohol? Y N How much?_______________ For how long?_______________

Do you use any street drugs? Y N If yes, please list______________________

Marital Status: ______Single ______Married ______Separated ______Divorced ______Widowed

Occupation: ____

Past Gynecologic History

Previously sexually active? Y N Currently sexually active? Y N

Have you been diagnosed with a sexually transmitted disease? Y N

If yes, please select below:

_____Gonorrhea _____Chlamydia ______Genital Warts _____HPV _____Herpes

_____Syphilis _____HIV

Date of beginning of last menstrual period ___________ Method of birth control ____________

Age of first period ________ Pain or cramping? Y N

Cycle length ______ Cycle Frequency ______ Flow: Light Moderate Heavy

Past abnormal pap smear? Y N

Have you had treatment from an abnormal pap smear? (Please list what and when) _________________

Have you received your Gardasil: Y N PARTIAL?

If applicable:

Last Mammogram: ________________________ Last Bone Density: ___________________________

Last Colonoscopy: _________________________

Wellness Visit Form **Obstetrical Associates of St. Luke's**

Note: this is a confidential record and will be kept in your doctor's office. Information contained on this form will not be released without your permission.

Review Of Systems: Are you CURRENTLY experiencing any of these problems? Please Circle.

General
Weight Changes >10 lbs
Fever
Fatigue
Headache

Skin
Rash/Sores
Mole Changes

Head and Neck
Visual Changes (not glasses)
Blurred Vision
Double Vision
Trouble Hearing
Sinus Problems
Sore Throat

Musculoskeletal
Joint Pain
Muscle Weakness
Muscle Pain

Respiratory/Lungs
Shortness of Breath
Wheezing
Cough
Sleep Apnea

Neuro
Numbness or tingling
Dizziness
Seizures

Cardiovascular
Chest Pain
Difficulty Breathing
Irregular rapid heartbeat
Swelling

Endocrine
Changes in hair/hair loss
Heat/Cold Intolerance
Frequent sweats/hot flashes
Excessive Thirst

Gastrointestinal
Nausea/Vomiting
Frequent heart burn/acid
Abdominal pain
Diarrhea (Frequent)
Constipation

Psych/Social
High anxiety/stress
Marital/relationship problems
Depressed mood/crying
Thoughts of Suicide
Forgetfulness/Confusion

Allergic/Immunologic
Hay Fever
Seasonal Allergies
Medications

Hematologic/Lymphatic
Swollen glands
Bruise/Bleed easily

Breast
Nipple Discharge
Lumps
Skin Changes

Covid-19 Vaccine
yes
no

Genitourinary/Women
Pelvic Pain
Urine Leakage
Vaginal discharge
Abnormal bleeding
Menopause
Painful Periods
Decreased sexual desire
Frequent Urination
Burning with Urination
Vaginal dryness
Menstrual problems
Infertility
Painful intercourse

If yes:
When? ________Circle one: Pfizer Moderna Johnson & Johnson **Booster?** Yes No

***If you are experiencing any of the problems above and would like them addressed at this appointment, please understand that your insurance may be billed for a larger amount. In result, you may be billed a copay, coinsurance or deducible amount from our office. ***