LAURA R. STONE, M.D., P.C.

NAME: ______________________ D.O.B:____________ AGE: ________ M S D W

DATE: ______________ OCCUPATION: ______________________

GENERAL MEDICAL

1. List all medications/vitamins/herbal supplements and their dosages: ______________________
____
2. List any medications you are allergic to and type of reaction: ______________________
____
3. Has your cholesterol been checked? No Yes If so, when ____________
   Was it normal? No Yes Cholesterol value: ________HDL ________
4. Have you ever been a smoker? No Yes # per day: ________ # yrs smoked: ________
   Are you a current smoker? No Yes If no, what year did you stop: ____________
5. Do you drink alcohol? No Yes How much: ____________
6. Do you use recreational drugs? No Yes How often: ________ Type(s): ________
7. Do you exercise? ________ Frequency &Type ______________________
8. Family Health History:

Relationship	Alive or Deceased	Current age or age at time of death	Medical Problems and / or Cause of Death
Mother	A or D		
Father	A or D		
Sibling F or M	A or D		
Sibling F or M	A or D		
Maternal Grandmother	A or D		
Maternal Grandfather	A or D		
Paternal Grandmother	A or D		
Paternal Grandfather	A or D		
Aunt M or P	A or D		
Uncle M or P	A or D		

9. Do you currently have:

Anxiety	□ cyclic	□ frequently	□ rarely	□ no
Cold hand / cold feet		□ frequently	□ rarely	□ no
Constipation		□ frequently	□ rarely	□ no
Decrease in energy level		□ frequently	□ rarely	□ no
Decrease in sexual drive		□ frequently	□ rarely	□ no
Depression	□ cyclic	□ frequently	□ rarely	□ no
Difficulty concentrating		□ frequently	□ rarely	□ no
Difficulty sleeping		□ frequently	□ rarely	□ no

Frequent headaches	□ cyclic	□ frequently	□ rarely	□ no
Hair loss		□ frequently	□ rarely	□ no
Hot flashes / hot flushes		□ frequently	□ rarely	□ no
Migraines	□ cyclic	□ frequently	□ rarely	□ no
Mood swings		□ frequently	□ rarely	□ no
Night sweats		□ frequently	□ rarely	□ no
Pain with intercourse		□ frequently	□ rarely	□ no
Recurrent bladder, kidney, or urinary tract infections		□ frequently	□ rarely	□ no
Urinary frequency or urgency		□ frequently	□ rarely	□ no
Urinary incontinence or dribbling		□ frequently	□ rarely	□ no
Urine leakage when coughing / sneezing		□ frequently	□ rarely	□ no
Vaginal dryness		□ frequently	□ rarely	□ no
Weight gain / weight loss		□ frequently	□ rarely	□ no

10. List any other medical problems: ______________________________

Health care providers seen in the last 2 years, including naturalists, chiropractors, holistic healers:

Health Care Provider   Specialty   Seen for

____

____

11. Do you have any **history** of any of the following and your age at onset of problem:

□ AIDS   □ Anemia   □ Anorexia / Bulimia   □ Asthma

□ Bleeding problems   □ Blood clots   □ Hepatitis   □ High blood pressure

□ Mitral Valve Prolapse   □ Psychiatric   □ Stroke

SURGICAL HISTORY – Please list all operations/surgeries and year performed ______________________________

____

BREASTS

1. Have you and/or a blood relative had breast cancer?   No   Yes

   If yes, at what age? __________ Relationship ______________________________
2. Do you do breast self-exams each month?   No   Yes
3. Do you have any breast pain or lumps?   No   Yes ____________________
4. Do you have any discharge from nipples?   No   Yes ____________________
5. Have all of your mammograms been normal?   No   Yes
6. When & where was you last mammogram? ____________________ Result: ____________________
7. Have you ever had any breast surgery?   No   Yes

   If yes, what type / outcome? ______________________________

SCREENINGS

Bone Density Scan: Have you had a bone density scan? ________ If yes, when & where? ____________________________

Colon/Bowel Cancer Screening: Stool checks for occult blood (cards) _______ No _______ Yes Year _________________

If you are over 50, have you ever been screened for bowel cancer? _______ No _______ Yes

Method of screening: Colonoscopy _______ No _______ Yes Year __________ by Dr. ___________________________

Flexible Sigmoidoscopy ______No _______Yes Year __________ by Dr. ___________________________

GYN HISTORY

1. # Pregnancies: ________ Deliveries: _______ Miscarriages: _______ Abortions: _______ Living Children: _________
2. Start date of last menstrual period: _____________________________________
3. Age at first menstrual period: _____________________________________
4. Length of cycle: (1st day of period to 1st day of next period) _____________________________________
5. How many days do you bleed each period? _____________________________________
6. Are your periods regular? (Approximately once a month) ______No _____ Yes
7. Do you bleed between periods? ______No _____ Yes
8. Do you have severe cramps with your period? ______No _____ Yes, what days _______
9. Date of last PAP smear: _____________________________________
10. Have you ever had an abnormal PAP smear? ______No _____ Yes, when ___________

    How was your abnormal PAP smear treated? Repeat PAP Colposcopy LEEP Cryo

CONTRACEPTION

11. What method of birth control are you using? ______ Birth control pills Name of pill: ________________________

    How many birth control pills do you forget to take, skip taking or take late each month? ________________________

    ____ Condoms ____Diaphragm ____Hysterectomy ____IUD

    ____ Rhythm/Natural ____Sponge ____Tubal ligation ____Vasectomy

    ____ Withdrawal ____None ____Not having sex ____Family planning

    Any problems or concerns with your current method of birth control? _____No ______Yes, describe_________________

    ____

12. Are you taking any hormone replacement therapy? _____ No _____Yes; name, dose, frequency ___________________
13. Are you currently sexually active? ______No ______Yes, if yes, ______Satisfied ______Unsatisfied: why__________

    ____

14. Number of sexual partners to date? _______ How long with current partner? ______ Any new partner(s) ___________
15. Have you ever had a sexually transmitted infection? ______No ______ Yes, which one(s)

    ______ AIDS ______ Chlamydia ______Genital warts ______ Gonorrhea

    ______ Herpes ______ H.P.V. ______Syphilis ______ Trichomonas

16. Would you like to be screened for any of the above? ______No ______ Yes, which ones _____________

    ____

17. Have you ever been, or are you currently being, physically, sexually, or emotionally abused? _______ No ______ Yes

    ______ Maybe,____

18. Have you had any other gynecological problems or treatment? ______ No ______Yes, explain ___________________

    ____

REASON FOR TODAY'S VISIT: Annual exam Gynecological problem Other

____

PHYSICAL EXAMINATION

NAME: ______________________ AGE:________ DATE:____________

BP ____________ P________ HT __________ WT __________ UA ___________ LMP ____________

GEN: NL ________________ URETHRAL MEATUS: NL ______________________

THY: NL ________________ VULVA: NL ________ VSEXAM__________________

BR: NL ________________ VAG: NL ______________________

NIPPLES NL ________________ CX: NL ______________________

AXILLA NL ________________ UTERUS: NSSC AV AF ML RV RF

BSEXAM ________________ ______________________

PUL: NL ________________ ADNEXA: LT: NL ______________________

COR: NL ________________ RT: NL ______________________

ABD: NL ________________ RECT: NOT DONE NO MASS ______________

HEME: NOT DONE NEG POS