TODAY'S DATE: _____

# Haugen OB/GYN Medicare Established Patient History

PATIENT NAME: _____ DATE OF BIRTH: _____

PRIMARY CARE PHYSICIAN: _____

PHARMACY NAME & CITY _____

Issues you want to discuss with your Provider today: _____

_____

**Menstrual History:** (Skip to next section if menopausal)
First day of last period: _____
____regular or ____irregular
How many days apart? _____
Flow: ____light ____moderate ____heavy
# of tampons or pads per 24 hours_____
How many days does your period last? _____
Cramps/pain ____mild ____moderate ____severe
Bleeding between periods? ____yes ____no

Birth control Method**:** _____

**Your age at menopause** _____

Did/do you take hormone replacement therapy?
____ yes ____ no
If yes, what and when? _____
Do you have ____hot flashes
____ night sweats
____ vaginal dryness

**Relationship Status:**

| | | |
|---|---|---|
| ___single | ___married | Partner is: |
| ___dating | ___divorced | ____ male |
| ___partnered | ___widowed | ____ female |
| | | ____ transgender |

**Are you sexually active?** ____ yes ____ no
Any problems with sexual activity? ____ yes ____ no

**Tobacco use:** ____ yes how much? _____
____ never
____ quit when? _____

**What do you do for exercise:** _____
how often: _____

**Current Occupation:** _____

Do you have a **Health Care Directive/Living Will?**
____yes ____ no
If no, would you like information on one?
____yes ____ no

**Medications** you are regularly taking, including prescription, over the counter, herbs, dietary supplements, inhalers, topical creams.
**Please include the dose.**

_____

_____

_____

_____

**Please check if you have any of the following in the past month:**

**Breasts:**
__lumps
__tenderness
__nipple discharge

**Gastrointestinal:**
__abdominal pain
__nausea or vomiting
__diarrhea
__constipation
__blood in stool
__incontinence of stool

**Genitourinary:**
__urinary urgency
__urinary frequency
__pain with urination
__incontinence/leaking urine
__abnormal vaginal discharge
__pelvic pain
__tingling
__numbness