

**I. PATIENT IDENTIFICATION (PLEASE PRINT)**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ Marital Status:  S  M  D  Sep  W  
 \_\_\_\_\_ Race: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Home Telephone No.: (\_\_\_\_) \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
 Work Telephone No.: (\_\_\_\_) \_\_\_\_\_ Primary Physician: \_\_\_\_\_

**II. REASON FOR SEEING DOCTOR:** \_\_\_\_\_

**III. MEDICAL HISTORY:**

Do you or anyone in your family have:

	You	Your Family
1. High Cholesterol .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Heart Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
3. High Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Thyroid Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Liver Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
8. Stomach or Bowel Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Kidney or Bladder Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
10. AIDS (HIV) .....	<input type="checkbox"/>	<input type="checkbox"/>
11. Hepatitis (Type ____ ) .....	<input type="checkbox"/>	<input type="checkbox"/>
12. Anemia / Blood Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>
13. Blood Transfusion .....	<input type="checkbox"/>	<input type="checkbox"/>
14. Osteoporosis .....	<input type="checkbox"/>	<input type="checkbox"/>
15. Cancer (Who and what type?) .....	<input type="checkbox"/>	<input type="checkbox"/>
16. Birth Defects or Inherited Diseases .....	<input type="checkbox"/>	<input type="checkbox"/>
17. Sexual Abuse / Domestic Violence .....	<input type="checkbox"/>	<input type="checkbox"/>
18. Depression or Psychiatric Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
19. Other Medical Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
20. <b>No Known Medical Problems</b> .....	<input type="checkbox"/>	<input type="checkbox"/>

Physicians Use Only

**IV. HOSPITALIZATIONS**

Please list those operations or serious illnesses that you have had which required hospitalization. If you have had more than six, check this box.  Do not include pregnancies here.

Month/Year	Illness or Operation	Attending Physician's Name	Complications	
			No	Yes
/			<input type="checkbox"/>	<input type="checkbox"/>
/			<input type="checkbox"/>	<input type="checkbox"/>
/			<input type="checkbox"/>	<input type="checkbox"/>
/			<input type="checkbox"/>	<input type="checkbox"/>
/			<input type="checkbox"/>	<input type="checkbox"/>
/			<input type="checkbox"/>	<input type="checkbox"/>

**V. PREGNANCY HISTORY (Complete all information)**

# of Pregnancies		# of Premature Births		# of Spontaneous Abortions		# of Elective Abortions		# of Living Children	
# of Term Births	Born Month/Year	Baby's Sex	Weight at Birth	Weeks Pregnant (Term=40 Wks)	Hours in Labor	Type of Delivery	Type of Anesthesia	Complications	
			lbs. oz.					No	Yes
1	/		lbs. oz.					<input type="checkbox"/>	<input type="checkbox"/>
2	/		lbs. oz.					<input type="checkbox"/>	<input type="checkbox"/>
3	/		lbs. oz.					<input type="checkbox"/>	<input type="checkbox"/>
4	/		lbs. oz.					<input type="checkbox"/>	<input type="checkbox"/>
5	/		lbs. oz.					<input type="checkbox"/>	<input type="checkbox"/>
6	/		lbs. oz.					<input type="checkbox"/>	<input type="checkbox"/>

Patient's Signature: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

**PAST GYN HISTORY:**

1. When was your last pap smear? \_\_\_\_\_ Where? \_\_\_\_\_
2. When was your last mammogram? \_\_\_\_\_
3. When was your last period? \_\_\_\_\_
4. How old were you when you first started menstruating? \_\_\_\_\_
5. How many days pass in between menstrual periods? \_\_\_\_\_
6. How long do your periods last? \_\_\_\_\_ days
7. Are your periods painful? \_\_\_\_\_ Mild Moderate Severe
8. What do you use to treat your pain? \_\_\_\_\_
9. Do you do self-breast exams? \_\_\_\_\_ How often? \_\_\_\_\_
10. Have you noticed any lumps, pain, or discharge? \_\_\_\_\_
11. Do you have any vaginal discharge, odor, or itching? \_\_\_\_\_
12. Are you sexually active? \_\_\_\_\_
13. How old were you when you first had sexual intercourse? \_\_\_\_\_
14. How many sexual partners have you had in your lifetime (total)? \_\_\_\_\_
15. Do you use birth control? \_\_\_\_\_ What type(s)? \_\_\_\_\_
16. Have you had problems with birth control in the past? \_\_\_\_\_
17. Have you ever had Gonorrhea, Chlamydia, HPV, or any other sexually transmitted diseases? \_\_\_\_\_  
If yes, when? \_\_\_\_\_

**If you are postmenopausal**, when did you go through menopause? \_\_\_\_\_

Do you have:

Hot Flashes? \_\_\_\_\_

Night Sweats? \_\_\_\_\_

Vaginal Dryness? \_\_\_\_\_

Mood Changes? \_\_\_\_\_

Do you leak urine? \_\_\_\_\_ When? \_\_\_\_\_ How often? \_\_\_\_\_

**MEDICATIONS:** Please list all medications / vitamins / herbs / supplements that you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:** Please list all medications you are allergic to and what happens if you take them, such as hives, rash, vomiting, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY:**

Do you smoke? \_\_\_\_\_ How many packs a day? \_\_\_\_\_

How many years have you been smoking? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ What kind? \_\_\_\_\_

How much alcohol do you drink in a week? \_\_\_\_\_

Do you use street drugs? What kind? \_\_\_\_\_

How much per day? \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

**PATRICIA A. FREY, M.D., P.A.**

4201 Garth Road, Suite 290  
Baytown, TX 77521

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

**IF YOU ARE PREGNANT, PLEASE ANSWER THE FOLLOWING:**

1. Excluding iron and vitamins, have you taken any medications or recreations drugs since being pregnant or since your last menstrual period? (Include nonprescription drugs.) Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, give name of medication and time taken during pregnancy: \_\_\_\_\_
2. Will you be 35 years or older when the baby is due? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?
  - Down syndrome Yes \_\_\_\_\_ No \_\_\_\_\_
  - Other chromosomal abnormality Yes \_\_\_\_\_ No \_\_\_\_\_
  - Neural tube defect, ie, spina bifida (meningomyelocele or open spine), anencephaly Yes \_\_\_\_\_ No \_\_\_\_\_
  - Hemophilia Yes \_\_\_\_\_ No \_\_\_\_\_
  - Muscular dystrophy Yes \_\_\_\_\_ No \_\_\_\_\_
  - Cystic Fibrosis Yes \_\_\_\_\_ No \_\_\_\_\_If yes, indicate the relationship of the affected person to you or to the baby's father: \_\_\_\_\_
4. Do you or the baby's father have a birth defect? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, who had the defect and what is it? \_\_\_\_\_
5. In any previous marriages, have you or the baby's father had a child, born dead or alive, with a birth defect not listed in question 2 above? Yes \_\_\_\_\_ No \_\_\_\_\_
6. Do you or the baby's father have any close relatives with mental retardation? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, indicate the relationship of the affected person to you or to the baby's father: \_\_\_\_\_  
Indicate the cause, if known: \_\_\_\_\_
7. Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal abnormality not listed above? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, indicate the condition and the relationship of the affected person to you or to the baby's father: \_\_\_\_\_
8. In any previous marriages, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses? Yes \_\_\_\_\_ No \_\_\_\_\_  
Have either of you had a chromosomal study?  
If yes, indicate who and the results: \_\_\_\_\_
9. If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, indicate who and the results: \_\_\_\_\_
10. If you or the baby's father are black, have either of you been screened for sickle cell trait? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, indicate who and the results: \_\_\_\_\_
11. If you or the baby's father are of Italian, Greek, or Mediterranean background, have either of you been tested for  $\beta$ -thalassemia? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, indicate who and the results: \_\_\_\_\_
12. If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for  $\alpha$ -thalassemia? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, indicate who and the results: \_\_\_\_\_
13. Do you have cats? Yes \_\_\_\_\_ No \_\_\_\_\_
14. Have you had Chicken Pox? Yes \_\_\_\_\_ No \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_