Jill Tirpack, M.D.

Office Use Only:
Ht. _____Wt.,_____
BP_____ Temp._____
P _____R _____
Allergies:_____

DATE: _____

NAME: _____

OCCUPATION: _____

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____

Main reason for office visit today:

Specific Problem **Duration**

_____

_____

_____

OBSTETRICAL HISTORY:

List ALL pregnancies (including miscarriages, abortions, etc.)

YEAR	LENGTH OF PREGNANCY	FACILITY OR HOSPITAL	COMPLICATIONS	BIRTH WT.	SEX
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____
4._____	_____	_____	_____	_____	_____

GYNECOLOGICAL HISTORY:

MENSTRUAL PERIODS

First day or last period_____

Age when you started:_____

How many days do you flow?_____

Menstrual cycle length:_____

(Length of time from the first day of your period to the start of your next period)

PAP SMEAR

Date of last pap smear:_____

Where was it done?: _____

MAMMOGRAM

Date of last mammogram_____

Where was it done?_____

Which of the following apply to you?

(Past or Present)	YES	NO
Painful periods	☐	☐
Bleeding between periods	☐	☐
Irregular periods	☐	☐
Abnormal Pap	☐	☐
DES daughter	☐	☐
Genital warts	☐	☐
Sexually Transmitted Disease	☐	☐
Pelvic Infection	☐	☐
Feeling that pelvic organs are falling out	☐	☐
Involuntary urine loss	☐	☐
Painful Intercourse	☐	☐

PAST MEDICAL HISTORY

Have <u>you</u> ever had any of the following:

	YES	NO		YES	NO
Diabetes	☐	☐	Migraine Headaches	☐	☐
Heart Disease	☐	☐	Digestive System Disorder	☐	☐
Mitral Valve Prolapse	☐	☐	Hypertension (High Blood Pressure)	☐	☐
Rheumatic Fever	☐	☐	Allergies	☐	☐
Kidney Disease	☐	☐	Cancer	☐	☐
Liver Disease	☐	☐	Breast Disease	☐	☐
Tuberculosis (TB)	☐	☐	Asthrma	☐	☐
Thyroid Disease	☐	☐	Emphysema	☐	☐
Epilepsy/Seizures	☐	☐	Pneumonia	☐	☐
Phlebities (Blood Clots in Veins)	☐	☐	Other_____		

_____ _____ _____

_____ _____ _____

_____ _____ _____

Previous hospitalizations other than surgery

Year	Surgery	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HABITS:

Have you ever or do you now:

1. Smoke?_____
2. Drink Alcohol?_____
3. Use Drugs?_____
4. Exercise?_____

MEDICATIONS:

Medicine you take & dose:

_____

_____

_____

_____

FAMILY HISTORY:

Any relatives with: **Who?**

High blood pressure?_____

Heart Disease?_____

Diabetes?_____

Breast Cancer?_____

Other Cancer?_____

Other Problems?_____

REVIEW OF SYSTEM:

Have you ever had any of the following problems?

CARDIOVASCULAR

Heart Trouble YES ☐
Heart Murmurs YES ☐
Rheumatic Fever YES ☐
Blood Clots (Legs or Lungs) YES ☐
High Blood Pressure YES ☐
Anemia YES ☐
Blood Transfusions YES ☐
Elevated Cholesterol YES ☐

PULMONARY

Chest Pains YES ☐
Pneumonia YES ☐
TB or Valley Fever YES ☐

GASTROINTESTTINAL

GallBladder Problems YES ☐
Yellow Jaundice (hepatitis) YES ☐
Ulcers YES ☐
Bloody Stools or Vomitus YES ☐
Bowel Habit Changes YES ☐
Colitis or Spastic Colon YES ☐

URINARY

Kidney Infection YES ☐
Bladder Infection YES ☐
Blood in Urine YES ☐

NEUROLOGICAL

Frequent Headaches YES ☐
Fainting Spells YES ☐
Convulsions YES ☐

ENDOCRINE

Thyroid Problems YES ☐
Diabetes YES ☐
Recent Weight Change YES ☐

OTHER

Breast Problems, Nipple Discharge YES ☐
Last Mammogram YES ☐
Cancer YES ☐
Depression YES ☐
Psychiatric Care YES ☐
Bone Problems YES ☐
Muscle Problems YES ☐