8001 Youree Drive, Suite 600
Shreveport, LA 71115

WK PIERREMONT
OB-GYN Specialists

(318) 212 - 3890
pierremontobgyn.com

Name:_____ **Age:**_____ **DOB:**_____ **Today's Date:**_____

Circle reason for visit: Yearly wellness visit, breast lump, breast pain, pelvic pain, menstrual period problems, vaginal discharge/itching/irritation, birth control, urinary incontinence, urinary tract or bladder infection, possibly pregnant, wanting to become pregnant, other: _____
_____

Pregnancy History

Have you ever been pregnant? Yes or No
If yes, please list each pregnancy in order – include any miscarriage or abortion

	Month/Year	vaginal/c-section/miscarriage	gestation at delivery	weight of infant
Example:	1. 6/2017	miscarriage	7 weeks	
	2. 10/2019	vaginal	38 weeks	7lb

Pregnancy #1 _____
Pregnancy #2 _____
Pregnancy #3 _____
Pregnancy #4 _____
Pregnancy #5 _____

Gynecologic History

Date of Last Menstrual Period: _____
Are you currently sexually active? Yes or No
If yes, what is your current method of contraception/birth control? _____
Have you had a hysterectomy? Yes or No *If yes, what type and what year?* _____
Date of last pap smear: _____
History of abnormal Pap smears? Yes or No *If yes, what year?* _____
History of sexually transmitted infection? Yes or No
If yes, please circle all that apply: Gonorrhea Chlamydia Trichomonas HIV Syphilis Herpes Hepatitis B or C

Personal Medical History

Who is your primary care physician (PCP)? _____
Please list any **medical problems or diagnoses** you have below

	Diagnosis	Date of diagnosis	Treatment	Supervising MD
Example:	Diabetes	11/2019	Insulin	Dr. Jane Doe

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list any **surgeries** you have had below

	Surgery	Year	Surgeon
Example:	abdominal hysterectomy	June 2015	Dr. Jane Doe

1. _____
2. _____
3. _____
4. _____
5. _____

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Name:_____ **Age:**_____ **DOB:**_____ **Today's Date:**_____

Please list all **medications** that you are currently taking – include any prescriptions, over the counter medicines, supplements, or herbal remedies.
Please let the nurse know if you have a written list with you rather than writing list below

	Medication	Dose
Example:	Nifedipine	30 mg once daily

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any **allergies** you have along with reaction
Example: Latex – itching/rash

1. _____
2. _____
3. _____
4. _____
5. _____

Family Medical History

Has anyone in your family ever had any of the following:

Breast cancer - Yes or No If yes, who? Age at diagnosis? _____
Ovarian cancer - Yes or No If yes, who? Age at diagnosis? _____
Uterine/Endometrial cancer - Yes or No If yes, who? Age at diagnosis? _____
Colon cancer - Yes or No If yes, who? Age at diagnosis? _____
Blood clot - Yes or No If yes, who? _____
Bleeding disorder - Yes or No If yes, who? _____
Please list any other significant family history: _____
_____

Routine Health Maintenance (if applicable)

Have you received a mammogram? If so, when? _____
Have you received a colonoscopy? If so, when? _____
Have you received a DEXA scan? If so, when? _____
Please describe any abnormal tests: _____

The above information was completed by _____. I testify that the information on this form is complete and correct to the best of my knowledge.

_____ _____ _____
Patient Signature (or guardian if <18) *Relationship to patient* *Today's Date*

_____
Print Name