Date:_____ Email completed form to info@soniarebelesmd.com or FAX to **424-358-5005**

SONIA REBELES, MD, FACOG

GYNECOLOGY, MINIMALLY INVASIVE GYNECOLOGIC SURGERY

☐ New Patient

☐ Established Patient (saw Dr. Rebeles in the last 3 yrs)

PATIENT'S NAME: _____ AGE:_____DOB: _____

Primary Care Provider: _____ How were you referred here? _____

Reason for today's visit: _____

Occupation: _____Partner's Name: _____☐None

GYNECOLOGIC HISTORY: (complete even if post-menopausal or no longer having periods)

First day of last menstrual period: _____/_____/_____ If postmenopausal, age at which periods stopped: _____

Age at first period:_____ Periods start every:_____days (if irregular, give a range)

Duration of bleeding:_____days Bleeding is ☐ Light ☐Moderate ☐Heavy

Does bleeding/spotting occur after intercourse? ☐Yes ☐No | Does bleeding/spotting occur between periods? ☐Yes ☐No

Is pain associated with periods? ☐Yes ☐No ☐Occasionally *If yes/occasionally, is it:☐Before menses ☐During menses
Is pain ☐Mild ☐Moderate ☐Severe

Date of last PAP smear: ____/____/____ | Have you had abnormal pap smears? ☐No ☐Yes

Have you had treatment for an abnormal pap? ☐No ☐Yes | If yes, specify what type and when: _____

Date of last Mammogram: _____/_____/_____ | Have you ever had an abnormal mammogram: ☐No ☐Yes

Date of last bone density: _____/_____/_____ | Date of last colonoscopy: _____/_____/_____

Do you have a sexual partner(s)? ☐No ☐Yes | Is your partner ☐Male ☐Female

Do you identify as: ☐Straight ☐Gay ☐Lesbian ☐Bisexual ☐Queer ☐Other (please specify) _____

How many sexual partners have you had: _____ in the past year _____ lifetime _____ currently

OBSTETRICAL HISTORY: (including abortions and tubal pregnancies)

Year	Weeks of Gestation	Type of Delivery Cesarean or Vaginal, Spontaneous or elective abortion	Complications Mother and/or Infant	Sex	Birth Weight	Present Health

PAST MEDICAL HISTORY: (Provide details below on all major health conditions or illness you have)

	Yes	No		Yes	No		Yes	No
Anemia			Endometriosis			Migraine headaches		
Anxiety			Frequent bladder infections			Polycystic ovarian syndrome PCOS		
Asthma			Heart problems			Seizures		
Breast cancer			High blood pressure			Stroke or thromboembolism		
Cancer (Leukemia, other)			Infertility			Sexually transmitted diseases		
Depression			Kidney disease			Thyroid disease		
Diabetes mellitus			Liver disease			Trauma/violence		
Eating disorder			Lupus			Other (specify below)		

Details of past medical history (any YES answers):_____

_____

PATIENT NAME:_____

(Last name, First name)

PAST SURGICAL HISTORY: (List all surgeries and month/year performed)

Surgery	Month/Year

CURRENT MEDICATIONS: (Include dose / amount per day) ☐No medications

Medication	Dose	Frequency

Have you ever taken birth control or hormone replacement and if yes, how many years?_____

ALLERGIES: List all allergies to medications ☐ None

_____

_____

SOCIAL HABITS:

Smoke ☐No ☐Yes ____packs/day x ____years ☐Prior smoker _____packs/day x ___ years | Quit date: _____

☐Never smoker | Alcohol use ☐No ☐Yes _____drinks per day/week/month/socially

Illicit drugs use ☐No ☐Yes _____(type) _____(frequency) Cannabis us ☐No ☐Yes _____(Amount)

Do you exercise? ☐No ☐Yes _____minutes _____days/week | Is your exercise regimen ☐Light ☐Moderate ☐Strenuous

What type of exercise do you do?_____

DEPRESSION SCREEN:

Over the past two weeks, how often have you been bothered by the following:	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

FAMILY HISTORY: **List any health conditions/illnesses of your family members and <u>indicate which family member affected</u>**

_____

_____

_____

Are there any other symptoms you are experiencing or anything else you would like Dr. Rebeles to know?

_____

_____

PATIENT SIGNATURE **DATE** **TIME**

PHYSICIAN SIGNATURE **DATE** **TIME**

Non-Discrimination Policy: Equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, gender identity or gender expression.