Date:_____

SOUTH BAY WOMEN'S HEALTH AND SURGERY

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: _____Spouse/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 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 How long have you had pain? _____

If yes, is it: ☐Before menses☐During menses☐After menses Pain is☐Mild ☐Moderate ☐Severe

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

If yes, when:_____

Date of last mammogram: _____ Have you ever had abnormal mammogram: ☐No ☐Yes

Date of last bone density: _____ If yes, when:_____

Date of last colonoscopy: _____

Do you have a sexual partner(s)?☐No ☐Yes Do you have sex with☐Men ☐Women ☐Both

Do you identify as: ☐Straight/Heterosexual ☐Gay ☐Lesbian ☐Bisexual ☐Queer ☐Trans ☐_____

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

OBSTETRIC HISTORY: (including abortions and tubal pregnancies)

Year	Weeks of Gestation	Type of Delivery (Cesarean or Vaginal) OR Abortion or Tubal Pregnancy	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: _____

_____

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 and reaction ☐None

Medication	Reaction (hives, trouble breathing, etc)	**Medication**	Reaction (hives, trouble breathing, etc)

SOCIAL HABITS:

Smoke/Vape☐No ☐Yes _____packs/day ☐Prior smoker _____packs/day Quit date: _____ ☐Never smoker
Alcohol use ☐No ☐Yes _____drinks per day / week / month / socially Type: _____
Illicit drug use ☐No ☐Yes _____(type) _____(frequency)
Cannabis use ☐No ☐Yes _____(amount) _____(frequency)
Do you exercise?☐No ☐Yes _____ minutes _____ days/week
Is your exercise regimen☐Light ☐Moderate ☐Strenuous
What type of exercise do you do?_____

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

Family Member	Health conditions/illnesses	**Family Member**	Health conditions/illnesses

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

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**