Dr. Nasha Reddy

Name: _____ Date of Birth: _____

To help Dr. Reddy in today's exam, please fill out completely.

Allergies to medications: _____

_____

Current medications & supplements (w/ dosages if known): _____

_____

_____

Medical History:

Please check if you have problems in the following areas. Enter details in space below.

- ☐ Heart
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Lungs
- ☐ Asthma
- ☐ Stomach/intestines
- ☐ Kidney/bladder
- ☐ Osteoporosis
- ☐ Muscular
- ☐ Diabetes
- ☐ Thyroid
- ☐ Migraine Headaches
- ☐ Seizures
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Cancer
- ☐ Depression
- ☐ Mental health history
- ☐ Anxiety
- ☐ Hepatitis
- ☐ HIV
- ☐ Gynecologic
- ☐ Bleeding between periods
- ☐ Problems with current birth control
- ☐ Pain w/ intercourse
- ☐ Pain w/ periods
- ☐ Sexually transmitted diseases
- ☐ Breast lump

Details: _____

_____

_____

OB/GYN history:

How many times have you been pregnant? (do not include current pregnancy) _____

Have you ever had any miscarriages? (# of) _____ or abortions? _____

How many deliveries have you had?_____ # of deliveries prior to 37 weeks? _____

Method of delivery? # of Vaginal _____ and/or # of C-Section _____

Did you have any problems during pregnancy?_____

How many children do you have?_____ How many step children? _____

At what age did you have your first period? _____ Date last period started: _____

If menopausal, how old were you when you went through menopause? _____

How do you prevent pregnancy?

- ☐ Abstinence (no intercourse)
- ☐ Birth Control Pills
- ☐ Condoms/spermicide
- ☐ Nuva Ring
- ☐ Essure (date)_____
- ☐ Pull out method
- ☐ Rhythm method
- ☐ Diaphragm
- ☐ Depo Provera
- ☐ IUD (date)_____
- ☐ Tubal ligation
- ☐ Hysterectomy
- ☐ Vasectomy in partner
- ☐ Nexplanon
- ☐ Attempting pregnancy

When was your last pap smear? _____ **Were results normal?** ○Yes ○No

Have you ever had an abnormal pap? ○Yes ○No When? _____

Did abnormal pap show 1 or more of the following? (circle if known) ☐HPV ☐ASCUS ☐Dysplasia

For abnormal pap, did you have any of the following done?

Colposcopy	○Yes	○No	When? _____
Biopsies	○Yes	○No	When? _____
Cone biopsy	○Yes	○No	When? _____
Laser	○Yes	○No	When? _____
Freeze (cryo)	○Yes	○No	When? _____

Have you ever had a mammogram? ○Yes ○No When? _____

Have you ever had an abnormal mammogram? ○Yes ○No When? _____

For abnormality, did you have? Ultrasound ○Yes ○No Results? _____

Biopsy ○Yes ○No Results? _____

Surgical History **(with date of surgery, include C-Sections if any):**

_____

_____

_____

Family history **(circle mother/father, brother/sister, maternal/paternal grandparent):**

☐ Diabetes	☐ Mom	☐ Dad	☐ Bro	☐ Sis	☐ MGM	☐ MGF	☐ PGM	☐ PGF
☐ High blood pressure	☐ Mom	☐ Dad	☐ Bro	☐ Sis	☐ MGM	☐ MGF	☐ PGM	☐ PGF
☐ Heart attack	☐ Mom	☐ Dad	☐ Bro	☐ Sis	☐ MGM	☐ MGF	☐ PGM	☐ PGF
☐ Stroke/Blood Clot	☐ Mom	☐ Dad	☐ Bro	☐ Sis	☐ MGM	☐ MGF	☐ PGM	☐ PGF
☐ Osteoporosis	☐ Mom	☐ Dad	☐ Bro	☐ Sis	☐ MGM	☐ MGF	☐ PGM	☐ PGF
☐ Depression	☐ Mom	☐ Dad	☐ Bro	☐ Sis	☐ MGM	☐ MGF	☐ PGM	☐ PGF

Family history of gynecologic cancers (parent, brother/sister, grandparent, aunt/uncle only):

☐ Breast **Who?** _____

☐ Ovarian **Who?** _____

☐ Uterine **Who?** _____

☐ Colon **Who?** _____

☐ Other Cancer type & Who _____

_____

Have you ever used tobacco? ○Yes ○No If yes # of packs/day? ____ or # of cigarettes/day?____

Number of years smoked? _____ Current tobacco user? ○Yes ○No Date quit?(MM/YY)_____

Do you consume alcoholic beverages? ○Yes ○No ○Very Rarely

# of servings/day? _____ or # of servings/week? _____ or # of servings/month? _____

Do you drink caffeine? ○Yes ○No ○Very Rarely

Coffee? # of cups/day? _____ or # of cups/week? _____ or # of cups/month? _____

Soda? # of cups/day? _____ or # of cups/week? _____ or # of cups/month? _____

Tea? # of cups/day? _____ or # of cups/week? _____ or # of cups/month? _____

Have you ever used illegal drugs? ○YES ○NO

How would you characterize use? (circle one) ○Experimentation ○Regular use ○Addict

If current user, what type and how often? _____

If past user, what type and when last used? _____

Have you ever been diagnosed with a sexually transmitted infection? ○YES ○NO

If so, which one(s)? _____

Signature_____ **Date** _____