OB/GYN Associates of Lancaster, Inc.

1532 Wesley Way
Lancaster, Ohio 43130-3387
Phone: (740) 653-5088
Fax: (740) 653-6361

Sarah L. Froman, MD, FACOG
Laurel J. Santino, MD, FACOG
Suzanne M. Barnhart, MD, FACOG
Brandie J. Shirey, MSN, CNP

APPOINTMENT:
DATE_____ DAY_____ TIME_____
PATIENT'S NAME_____
WHY ARE YOU VISITING THE DOCTOR
TODAY?_____
_____
_____

SOCIAL HISTORY: Check (√) Fill in blank spaces where appropriate.
Single □ Married □ Separated □ Divorced □ No. years married_____
Married more than once? Yes □ No □ How many times?_____
HUSBAND: Age_____ Height_____ Weight_____ Health_____
Do you habitually use laxatives? Yes □ No □ How long? _____
Do you Tobacco? Yes □ No □ Amount/Day_____ Yrs of use_____
Do you Alcohol? Yes □ No □ Amount/Day_____ Yrs of use_____
Do you use Marijuana? Yes □ No □ Amount/Day_____ Yrs of use_____
Do you use Cocaine or other drugs? Yes □ No □ Amount/Day_____ Yrs of use_____
Have you ever lived in a foreign country? Yes □ No □ If so, where?_____
MENSTRUAL HISTORY
Please answer each question. Check (√) either Yes □ or No □. Fill in the blank spaces where appropriate.
Menstruated first time at the age of _____
At first periods were: regular □ irregular □
Last menstrual period started on _____
Was it normal? Yes □ No □ Previous menstrual period_____
What is your normal weight?_____Lbs. Gain or loss in the last six months_____
Up to this time, periods have been regular □ somewhat irregular □ irregular □
If periods have been regular, the interval from one period to the next is _____ days.
If irregular, interval between periods range from_____ to _____ days.
Menstrual flow usually is: scant □ moderate □ heavy □ excessive □ length in days_____
Do you usually have clots with your period? Yes □ No □
Are your periods usually painful? Yes □ No □ If painful: mild □ moderate □ severe □ incapacitating □
Any other symptoms associated with your periods? Yes □ No □ List please _____
Are you sexually active? Yes □ No □ Do you have sex with: Men □ Women □ Both □
Do you have difficulty with desire, arousal, or orgasm? Yes □ No □
Are you satisfied with your sexual activity? Yes □ No □
Have you had more than one sexual partner in your life? Yes □ No □
Do you ever have bleeding or spotting following sexual intercourse? Yes □ No □
Do you ever have pain with sexual intercourse? Yes □ No □
Do you ever have a vaginal discharge? Yes □ No □
When was your last cancer pap smear made?_____
Have you ever had an abnormal pap smear? Yes □ No □
When was your last bone density scan? _____
When was your last mammogram?_____
Have you ever missed your periods without being pregnant? Yes □ No □
WHAT ARE YOU USING TO PREVENT PREGNANCY?_____
Are you satisfied with this method? Yes □ No □
PREGNANCY RECORD

How many?	Pregnancies		Full Term		Premature	
	Miscarriages		Abortions		Living Children	