Rapid City OB/GYN
Dr. Rochelle Christensen

Name: _____ Age: _____ Marital Status: S M D W

Your Occupation: _____

Primary Care/Referring MD: _____ Do you want records sent? _____

Chief Concern: _____

Obstetric History

Total Number of Pregnancies:___

How many were:

Full term: ___ Premature ___ Miscarriages: ___ Abortions: ___

Menstrual History

- Date of Last Menstrual Cycle: _____ ❑ Post menopause
- Age of First Menstrual Cycle: _____
- Menstrual Cycle comes every ___ days and lasts ___ days
- Cycles are ❑ Regular ❑ Irregular ❑ Painful
- Cycle Flow is: ❑ Light ❑ Light to Moderate ❑ Moderate to Heavy ❑ Heavy

Gynecologic History

- Age you became sexually active: ____ Are you currently sexually active? ❑ Yes ❑ No
- Current Method of Birth Control: ❑ Condoms ❑ NuvaRing ❑ Partner with vasectomy ❑ Pills ❑ Depo-Provera ❑ Tubal or Essure ❑ Patch ❑ IUD ❑ Implanon/Nexplanon ❑ Natural Family Planning ❑ None
- Have you ever had any of the following: ❑ HPV ❑ HIV ❑ Herpes ❑ Chlamydia ❑ Gonorrhea ❑ Syphilis ❑ Hepatitis B ❑ Hepatitis C ❑ Trichomonas ❑ Never had any

Screening History

- Date of Last Annual Exam: _____
- Date of Last PAP: _____ ❑ Normal ❑ Abnormal

  Have you ever needed any of the following procedures for an abnormal PAP?

  ❑ Colposcopy ❑ LEEP ❑ Freezing (Cryo) ❑ Conization ❑ None
- Date of last Mammogram: _____ ❑ Never had one
- Date of last Bone Density Scan: _____ ❑ Never had one
- Date of last Colonoscopy: _____ ❑ Never had one

Surgical History

	Dates
❑ Hysterectomy ❑ Vaginal ❑ Abdominal ❑ Bladder Sling	
❑ Ovary Removal ❑ Left ❑ Right ❑ Both	
❑ Fallopian Tube Removal ❑ Left ❑ Right ❑ Both	
❑ Tubal Ligation	
❑ C-Section	
❑ Laparoscopy	
❑ Appendix Removal	
❑ Gallbladder Removal	
❑ Bladder Repair	
❑ D&C	

List any other surgeries you have had below.

_____

Social History

Alcohol use ❑ Yes ❑ No If yes ____ Drink(s) per ❑ Day ❑ Week ❑ Month ❑ Special occasions

Tobacco use ❑ Yes ❑ Never ❑ Quit If YES or Quit: ____ pack(s) per day for ____ years

Allergies

Allergies	Reaction
❑ No Known Allergies	
❑ Latex	_____
❑ Penicillin	_____
❑ Sulfa Drugs	_____

List any other Allergies you may have!

_____

_____

_____

_____

_____

_____

Medications

Please list any medications, (prescription and over-the-counter) you currently take.

❑ **Currently taking No Medications**

❑ **See Medication List**

Victim of Domestic Violence? ❑ Yes ❑ No Are you safe now? _____

YOUR Past Medical History

❑ Heart Murmur
❑ High Cholesterol
❑ Heart Attack
❑ High Blood Pressure
❑ Stroke
❑ Asthma
❑ GERD
❑ IBS
❑ Kidney Stones
❑ Osteoporosis
❑ Osteopenia
❑ Epilepsy
❑ MTHFR
❑ Diabetes ❑ Type 1 ❑ Type 2
❑ Depression
❑ Anxiety
❑ Thyroid Disorder
❑ Anemia
❑ Cancer Type: _____
❑ Blood Transfusion Year:_____
❑ Polycystic Ovarian Syndrome
❑ Ovarian Cysts
❑ Endometriosis
❑ Uterine Fibroids
❑ DVT
❑ Pulmonary Embolism
❑ Arthritis
❑ Fibromyalgia
❑
❑
❑
❑

Family History

❑ Heart Disease
❑ High Blood Pressure
❑ Lung Disease
❑ Diabetes
❑ Stroke
❑ Thyroid Disease
❑ Blood Disorder
❑ Osteoporosis
❑ Kidney Disease
❑ Breast Cancer
❑ Ovarian Cancer
❑ Endometrial Cancer
❑ Cervical Cancer
❑ Colon Cancer
❑ Other

Patient Signature _____ Date _____

Physician Signature _____ Date _____