MERIDIAN PRIMARY CARE

Carlo Gopez, MD *Helene Lee, MD*
115 North Bridge Street, Elkton, MD 21921

Patient's Name:_____DOB: _____ Date: _____

Medications: _____

Please answer the following questions so that we may better serve your health needs.

Your Age: _____ Allergies: _____

If you have ever been pregnant, please indicate the number of the follow:

Pregnancies _____ Full-term live births _____ Premature live births _____
Abortions _____ Miscarriages _____ Living children _____

Age when you had your first menstrual period:_____
When was your last mammogram (x-ray of your breasts): _____ _____
When was the FIRST day of your most recent period: _____
If menopausal, have you had a hysterectomy? [ ] Yes [ ] No
Do you have any bothersome menopausal symptoms? _____
Are you on hormone replacement therapy? [ ] Yes [ ] No
When was your last PAP smear? [ ] Never [ ] 1 yr ago [ ] 2 yr [ ] ≥ 3 yr
Were the results normal? [ ] Yes [ ] No
Have you ever had an abnormal PAP test? [ ] Yes [ ] No
If yes, did you have further evaluation (e.g. colpo, biopsy, rePAP, etc.): _____
How often do you usually get your period? Every _____ days or [ ] No periods
Are your periods regular? [ ] Yes [ ] No How long do they last? _____days
The blood flow is generally: [ ] Light [ ]Moderate [ ] Heavy
Do you have vaginal bleeding between periods? [ ] Yes [ ] No
If menopausal, have you ever started bleeding again? [ ] Yes [ ] No
Do you have any vaginal discharge that is different from your usual? [ ] Yes [ ] No
Are you sexually active? [ ] Yes [ ] No
Do you and your partner(s) use some form of birth control? [ ] Yes [ ] No
Method: _____
Do you and your partner(s) use some form of STD protection? [ ] Yes [ ] No
Method: _____
Have you ever had a sexual transmitted disease (STD)? [ ] Yes [ ] No
Have you ever used fertility drugs? [ ] Yes [ ] No
Has your mother ever taken a hormone called DES (diethylstilbestrol)? [ ] Yes [ ] No
Do you smoke? [ ] Yes [ ] No How much per day? _____
How often do you perform self breast exams? [ ] Never or Other:_____
Has anyone ever abused or hurt you, either physically or verbally: [ ] Yes [ ] No
Do you feel safe?: [ ] Yes [ ] No
Do you have any family history of:
Breast Cancer: [ ] Yes [ ] No Family member: _____
Colon Cancer: [ ] Yes [ ] No Family member: _____
Uterine Cancer: [ ] Yes [ ] No Family member: _____
Ovarian Cancer: [ ] Yes [ ] No Family member: _____
Other Cancers: [ ] Yes [ ] No Family member & type: _____
Heart Disease: [ ] Yes [ ] No Family member: _____
On a scale of 1 to 10 (10 being the most severe) how would you rate your:
Premenstrual symptoms: 0 1 2 3 4 5 6 7 8 9 10
Pain during sex: 0 1 2 3 4 5 6 7 8 9 10
Pain during your usual period: 0 1 2 3 4 5 6 7 8 9 10

Please list any other concerns: _____