TAMMY E. BAKER, MD

OBSTETRICS  ***GYNECOLOGY***

Patient Agenda Form

Please take a moment to answer the questions below in order to best use the time spent with your provider.

Name: _____ Date: _____

1. What concerns do you want to be sure to discuss at today's appointment?

_____
_____
_____

2. What symptoms do you want your provider to be aware of?

_____
_____

3. What providers (hospital, Emergency Room, Urgent Care Clinic, Specialist, etc.) have you seen since your last visit?

_____
_____

4. Please list any medication changes (including OTC, vitamins and supplements)

Drug Name: Dose: Time(s) of Day Taken Refill needed? (30 or 90 days)

_____
_____
_____

5. Please list your preferred pharmacy (name, phone #, location including zip code):

_____

6. Please list all allergies: _____

7. Do you have specific requests for:
   - -New medications: _____
   - -Tests/Referrals: _____
   - -Completion of forms: _____
   - -Work/School forms: _____

8. Have you been prescribed a narcotic by any provider in the last 30 days? _____

9. Contact Information

Cell #: _____ Receive text/voice notification reminders: yes or no

Home #: _____ Work #: _____

E-mail address for reminders:

Preferred method of communication (circle one): Cell Work Home Mail E-mail

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Annual Physical Review

Name: _____ Reason for Visit: _____

Women who are not in a monogamous relationship or who have had more than one sex partner in the last year or who are under the age of 25 and have ever been sexually active should undergo annual screening for sexually transmitted diseases (STD). Would you like testing done today? □ Yes □ No

***ALLERGIES: _____

□Single □ Married □ Divorced □ Separated □ Widowed □ Domestic Partner

Sexual Orientation: □ Heterosexual □ Bisexual □ Lesbian

Menstrual History:

Last Menstrual Period: _____ # Days of Flow: _____

Amount: (heavy, normal, light) _____ Length between Periods: _____

Have you ever been pregnant? □Yes □ No How many times: _____ Vaginal Deliveries (#) _____ Cesarean (#) _____

How old were you when you first had intercourse: _____

Are you currently sexually active? □ Yes □ No

In your sexual history, have you had □ more than □ less than six (6) partners in your lifetime?

What form of birth control do you currently use? □ Pills □ IUD □ Diaphragm □ Vasectomy □ Norplant

□ Depo Provera □Tubal Ligation □Condoms □ Abstinence □ Rhythm Method □ None Needed

Do you use hormone replacement? □ Yes □ No Rx: _____

Medical History: Check if you have had any of the following:

□ Cancer	□ Abnormal Pap Smear	□ Pelvic Infection
□ Sexually Transmitted Disease	□ Phlebitis / Blood Clots in Legs	□ High Blood Pressure
□ Heart Disease	□ Mitral Valve Prolapse	□ High Cholesterol
□ Migraine Headaches	□ Anemia	□ Thyroid Problems
□ Diabetes	□ Tuberculosis	□ Hepatitis
□ Depression	□ Alcoholism	□ Digestive problems
□ Drug Addiction	□ Infertility	

Please list any medication that you are currently taking: _____

_____

Date of Last:

Colonoscopy: _____ Bone Density: _____ HPV Vaccine: _____ (Gardasil)

Do you perform breast exams on yourself? □Yes □ No How often? _____

Have you had a mammogram on your breasts? □ Yes □ No If so, when? _____

Have you ever had an abnormal mammogram? □ Yes □ No If so, when? _____

Have you ever had an abnormal pap smear? □Yes □No If yes, What kind of treatment? _____

Do you have a pap smear yearly? □ Yes □ No

(PLEASE COMPLETE BACK SIDE OF PAGE)

Surgical History:

Have you had any female surgery? □ Yes □ No If so, what type? (check the following): □ Breast □ Hysterectomy □ D&C □ Ectopic Pregnancy

□ Fibroid Tumors □ Ovary □ Laparoscopy □ Cesarean Section □ Laser/ LEEP/ Cryo of Cervix □ Other

Reason for Surgery/ Findings: _____

_____

Please list any other surgery: (i.e., appendectomy, heart surgery) _____

_____

Have you ever smoked? □ Yes □ No How Much? _____ □ Quit Years? _____

Do you drink alcohol? □ Yes □ No How Much? _____ How Often? _____

Do you use street drugs? □ Yes □ No What Kind? _____ How Often? _____

Are you or have you ever been threatened or physically, sexually, or mentally abused? □ Yes □ No

Family History: (*Siblings, Parents, Grandparents*) Please check appropriate box if a family member currently has or previously had one of these illnesses. Check every listing.

□ Breast Cancer _____ □ Ovarian Cancer _____

□ Other Cancer _____ □ Birth Defects _____

□ Heart Attack _____ □ High Blood Pressure _____

□ Tuberculosis _____ □ High Cholesterol _____

□ Diabetes _____ □ Bleeding Disorder _____

□ Alcoholism _____ □ Intellectual Development Disorder _____

□ Other _____

Review of Systems- *Please check if you are having problems with any of the following:*

Genital / Urinary: □ Vaginal Warts □ Heavy Vaginal Bleeding □ Painful Intercourse □ Urination at Night □ Vaginal Dryness □ Urinary Urgency

□ Irregular Vaginal Bleeding □ Bladder Control / Leakage □ Painful Menstrual Period □ Pain/Burning with Urination □ Urinary Tract Infection

Endocrine: □ Fatigue □ Hair Loss □ Absence of Menstrual Periods □ Hot Flashes

Skin/Breast: □ Nipple Discharge □ Sore That Does Not Heal □ Changes in Mole □ Rashes/Persistent Itching □ Breast Lumps/Tenderness

Neurological: □ Frequent Headaches □ Poor Coordination □ Muscle Weakness □ Trouble Sleeping

Psychiatric: □ Depression □ Anxiety □ Memory Changes □ Counseling or Treatment □ Mood Swings

ENT: □ Visual Problems □ Allergies/Hayfever □ Frequent Sore Throat □ Mouth Ulcers □ Hearing Loss □ Hoarseness □ Sinus Problems

Digestive: □ Heart Burn □ Rectal Bleeding □ Diarrhea □ Yellow Jaundice □ Vomiting □ Black Stools □ Significant Weight Change (i.e., < or > 10-15lbs./yr.)

Cardiac: □ Chest Pain □ Irregular Heart Beat □ Fainting/Dizziness

Respiratory: □ Shortness of Breath □ Coughed Blood □ Wheezing

Musculoskeletal: □ Joint Pain/ Swelling □ Muscle Pain □ Back Pain