Advance Gynecology & Wellness Dr. David Marden, D.O.
Phone: 423.844.5640 Fax: 423.844.5645

Date:_____
Name:_____ DOB:_____ Age:_____
Primary Care Physician:_____ Consult/Referred by:_____
Reason for Visit:_____
_____
Medications: (name, dose, frequency) _____
_____
_____
Drug Allergies: _____
Latex Allergies: _____

Past Medical History: (circle all that apply)

Hypertension	Diabetes		Stroke		Hepatitis Seizures
Frequent UTI	Lung problems		Incontinence	Asthma	Bowel problem
Heart disease	Liver disease		Eye problems	Ulcers	Osteoporosis
Skin problems	Arthritis	Kidney disease	GI reflux		
Hearing problem	Psychiatric disorder	Cancer: _____			

Other: _____

On a scale from 1-10 (1=unhealthy, 10=healthy) How Healthy do you feel? _____

Past Surgical History: (list all past surgeries and date) _____
_____
_____

Family History: (circle yes or no, if yes please explain)
Breast Cancer yes/no _____ Blood Disorders yes/no _____
GYN cancer yes/no _____ Heart Disease yes/no _____
Diabetesyes/no _____

Social History: (circle yes or no, if yes please explain)
Do you smoke yes/no _____ Do you drink yes/no _____
Do you use drugs yes/no _____ Do you exercise yes/no _____
Your Occupation _____ Marital status S M W D P
Spouse first name _____

GYN History
Last Menstrual Period: _____ Period problems: _____
Pregnancies: how many_____ Deliveries _____ Largest baby_____
Have you ever had an abnormal pap yes/ no _____
History of Sexually Transmitted Diseases yes/no _____
Do you have Incontinence problems (leaking urine) yes/no _____

Last Pap smear: _____ Results: _____
Last Mammogram: _____ Results:_____
Last Colonoscopy: _____ Results: _____
Last Bone Density Scan: _____ Results: _____
Last Thyroid Screening: _____ Results:_____
Last Cholesterol Screening: _____ Results: _____

Sexual History
Are you sexually active? yes/no Pain with Intercourse? yes/no Problems with orgasms? Yes/no

Abuse History
Is anyone hitting or hurting you yes/no