

PATIENT NAME: \_\_\_\_\_  
 BIRTH DATE: \_\_\_\_\_ AGE \_\_\_\_\_  
 ID NO.: \_\_\_\_\_  
 DATE: \_\_\_\_\_

  
 Magdalene Karon, M.D., F.A.C.O.G.  
 160 N. Eagle Creek Dr., Suite 205  
 Lexington, Kentucky 40509  
 (859) 277-3135 - Fax: (859) 276-4690  
 Obstetrics, Gynecology  
 Infertility

### PHYSICIAN HISTORY

<input type="checkbox"/> NEW PATIENT	<input type="checkbox"/> ESTABLISHED PATIENT	<input type="checkbox"/> CONSULTATION	<input type="checkbox"/> REPORT SENT: / /
PRIMARY CARE PHYSICIAN:		WHO SENT PATIENT:	
OTHER PHYSICIAN(S):			
CHIEF COMPLAINT (CC) (REQUIRED FOR ALL VISITS EXCEPT PREVENTIVE):		CURRENT PRESCRIPTION MEDICATIONS: <input type="checkbox"/> NONE	
HISTORY OF PRESENT ILLNESS (HPI):		CURRENT NONPRESCRIPTION, COMPLEMENTARY, AND ALTERNATIVE MEDICATIONS: <input type="checkbox"/> NONE	
CHANGES SINCE LAST VISIT		NOTES	
ILLNESSES	YES NO		
SURGERY	<input type="checkbox"/> <input type="checkbox"/>		
NEW MEDICATIONS	<input type="checkbox"/> <input type="checkbox"/>		
CHANGE IN FAMILY HISTORY	<input type="checkbox"/> <input type="checkbox"/>		
NEW ALLERGIES	<input type="checkbox"/> <input type="checkbox"/>		
CHANGE IN GYNECOLOGIC HISTORY	<input type="checkbox"/> <input type="checkbox"/>		
CHANGE IN OBSTETRIC HISTORY	<input type="checkbox"/> <input type="checkbox"/>		
ALLERGIES (DESCRIBE REACTION): <input type="checkbox"/> NONE			
LAST CERVICAL CANCER SCREENING: <input type="checkbox"/> CYTOLOGY / / <input type="checkbox"/> HPV TEST / /			
LAST MAMMOGRAM: / /			
LAST COLORECTAL SCREENING: / /			

### GYNECOLOGIC HISTORY (PH)

LMP: / /	AGE AT MENARCHE: _____	LENGTH OF FLOW: _____	INTERVAL BETWEEN PERIODS: _____	RECENT CHANGES: _____
SEXUALLY ACTIVE <input type="checkbox"/> YES <input type="checkbox"/> NO	EVER HAD SEX <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF PARTNERS (LIFETIME): _____		
PARTNERS ARE: <input type="checkbox"/> MEN <input type="checkbox"/> WOMEN <input type="checkbox"/> BOTH				
CURRENT METHOD OF CONTRACEPTION:		PAST CONTRACEPTIVE HISTORY:		

### OBSTETRIC HISTORY (PH)

PREGNANCIES		NUMBER	ABORTIONS		NUMBER	MISCARRIAGES		NUMBER
PREMATURE BIRTHS (<37 WEEKS)			LIVE BIRTHS			LIVING CHILDREN		
NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	PHYSICIAN'S NOTES		
1.								
2.								
3.								
4.								
ANY PREGNANCY COMPLICATIONS?								
<input type="checkbox"/> DIABETES <input type="checkbox"/> HYPERTENSION/HIGH BLOOD PRESSURE <input type="checkbox"/> PREECLAMPSIA/TOXEMIA <input type="checkbox"/> OTHER								
ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? <input type="checkbox"/> NO <input type="checkbox"/> YES, HOW TREATED								

### PAST HISTORY (PH)

<input type="checkbox"/> NONCONTRIBUTORY	<input type="checkbox"/> NO INTERVAL CHANGE SINCE: / /
SURGERIES:	
ILLNESSES (PHYSICAL AND MENTAL):	
INJURIES:	
IMMUNIZATIONS/TUBERCULOSIS TEST:	

**PHYSICIAN HISTORY (Continued)**

*Magdalene Karon, M.D.*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /
---------------	-----------------	---------	-----------

**FAMILY HISTORY (FH)**

<input type="checkbox"/> NONCONTRIBUTORY <input type="checkbox"/> NO INTERVAL CHANGE SINCE: / /			
MOTHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED-CAUSE:	AGE:	FATHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED-CAUSE:	AGE:
SIBLINGS: NUMBER LIVING:	NUMBER DECEASED:	CAUSE(S)/AGE(S):	
CHILDREN: NUMBER LIVING:	NUMBER DECEASED:	CAUSE(S)/AGE(S):	
<small>(IF YES, INDICATE WHOM AND AGE AT DIAGNOSIS)</small>			
<input type="checkbox"/> DIABETES	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> HYPERLIPIDEMIA	
<input type="checkbox"/> CANCER	<input type="checkbox"/> HYPERTENSION	<input type="checkbox"/> DEEP VEIN THROMBOEMBOLISM/PULMONARY EMBOLISM	
<input type="checkbox"/> OSTEOPOROSIS	<input type="checkbox"/> OTHER ILLNESSES		

**SOCIAL HISTORY (SH)**

<input type="checkbox"/> NONCONTRIBUTORY <input type="checkbox"/> NO INTERVAL CHANGE SINCE: / /			
	YES	NO	NOTES
TOBACCO USE	<input type="checkbox"/>	<input type="checkbox"/>	DIET DISCUSSED
ALCOHOL USE—SPECIFY AMOUNT AND TYPE <small>(12 OZ BEER = 5 OZ WINE = 1½ OZ LIQUOR)</small>	<input type="checkbox"/>	<input type="checkbox"/>	FOLIC ACID INTAKE
ILLEGAL/STREET DRUG USE	<input type="checkbox"/>	<input type="checkbox"/>	CALCIUM INTAKE
MISUSE OF PRESCRIPTION DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	REGULAR EXERCISE
INTIMATE PARTNER VIOLENCE	<input type="checkbox"/>	<input type="checkbox"/>	CAFFEINE INTAKE
SEXUAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	ADVANCE DIRECTIVE (LIVING WILL)
HEALTH HAZARDS AT HOME/WORK	<input type="checkbox"/>	<input type="checkbox"/>	ORGAN DONATION
SEAT BELT USE	<input type="checkbox"/>	<input type="checkbox"/>	OTHER
			<input type="checkbox"/> NO CHANGES SINCE: / /

EMPLOYER/SCHOOL: \_\_\_\_\_

OCCUPATION/STUDENT: \_\_\_\_\_

FULL-TIME/PART-TIME (Please Circle)      HOW LONG: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_

EMPLOYER/SCHOOL: \_\_\_\_\_

OCCUPATION/STUDENT: \_\_\_\_\_

FULL-TIME/PART-TIME (Please Circle)      HOW LONG: \_\_\_\_\_

WHOM MAY WE THANK FOR YOUR REFERRAL?: \_\_\_\_\_