Ashland Natural Medicine

Nm 97520

Dr. Ajana Miki

GYN Patient Information

Name _____ Today's Date _____

Age: _____ DOB: _____

1. Marital Status: ☐ Single ☐ Married ☐ Long-Term Relationship

☐ Divorced ☐ Widowed

2. Reason for this visit: _____

3. Referring Physician: _____

4. Occupation: _____

5. Primary Phone Number: _____

Menstrual History:

(Complete even if post-menopausal or no longer having periods.)

1. Age of first period: _____ years old.

2. If your Menstrual periods are regular; periods start every _____ days.

3. If your Menstrual periods are irregular; periods start every

_____ to _____ days. (e.g., 12 to 60)

4. Duration of bleeding: _____ days.

5. Does bleeding or spotting occur between periods? ☐ Yes ☐ No

6. Does bleeding or spotting occur after intercourse? ☐ Yes ☐ No

7. First day of last Menstrual period: _____

8. Is pain associated with periods? ☐ Yes ☐ No ☐ Occasionally

9. If yes, is it: ☐ before menses ☐ during menses ☐ both

<u>Pregnancy History</u> (All pregnancies): ☐ HAVE NEVER BEEN PREGNANT

OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES:

Number of pregnancies	Number of live births	Number of miscarriages	Number of abortions

Please describe any complications in birth/s or pregnancies:

_____

_____

_____

<u>Birth Control History</u>:

What birth control method(s) do you currently use?

_____

<u>Sexual History</u>:

1. Do you have a sexual partner? ☐ No ☐ Yes: ☐ Male ☐ Female

2. Are there concerns about your sexual activity in which you may want to discuss with your doctor? ☐ Yes ☐ No

<u>Past Obstetrical/Gynecological Surgeries</u>:

Check any that apply or ☐ NONE

Surgery	Year	Surgery	Year
☐ D&C	_____	☐ Ovarian Surgery	_____
☐ Hysteroscopy	_____	☐ L Cyst(s) removed ovarian	_____
☐ Infertility Surgery	_____	☐ R Cyst(s) removed ovarian	_____
☐ Tuboplasty	_____	☐ L ovary removed	_____
☐ Tubal Ligation	_____	☐ R ovary removed	_____
☐ Laparoscopy	_____	☐ Cesarean section	_____

☐ Hysterectomy (vaginal) _____ ☐ Hysterectomy (abdominal) _____

☐ Myomectomy _____ ☐ Vaginal or bladder repair for prolapsed or incontinence _____

☐ Other (please specify) _____ _____

Past Surgical History (NOT OB/GYN):

List all surgeries and their year or ☐ NONE

Surgery	Month/Year	Complications

PAP Smear/Mammogram History:

1. Date of last pap smear: _____ ☐ Normal ☐ Abnormal

2. Have you had abnormal pap smears? ☐ No ☐ Yes

3. Have you had treatment for an abnormal smear? ☐ No ☐ Yes

4. If yes, what type(s) of treatment have you had?

Treatment	Year	Treatment	Year
☐ Cryotherapy	_____	☐ Cone Biopsy	_____
☐ Laser	_____	☐ Loop excision (LEEP)	_____

5. Date of last mammogram: _____

6. Have you had an abnormal mammogram? ☐ No ☐ Yes

Other Past Gynecological History:

Check any that apply or ☐ NONE

☐ Venereal Warts ☐ Herpes-genital ☐ Syphilis

☐ Endometriosis ☐ Chlamydia ☐ Gonorrhea

☐ Vaginal Infections ☐ HPV

☐ Other (specify)_____

Past Medical History: **Check any that apply or ☐ NONE**

☐ Arthritis ☐ Gallstones ☐ Emphysema

☐ Liver Disease, includes Hepatitis ☐Bronchitis

☐ Diabetes:

☐ Diet controlled ☐ Insulin Controlled

☐ Pill controlled ☐ Gestational

☐ Blood Clots, Leg/Thigh ☐ Blood Transfusions ☐ Epilepsy

☐ HIV+ ☐ Eating Disorder ☐ Heart Disease

☐ High Blood Pressure ☐ Asthma ☐ Breast Cancer

☐ Thyroid Disease ☐ Kidney Disease

☐ Cancer (specify)_____

☐ Other (specify)_____

Current Medications: (include dose/amount per day)

Medication	Dose	Frequency

Do you currently?

Smoke: ☐ Cigarettes ☐ VAP ☐ Hooka

☐ Never ☐ Former, years smoked: _____

☐ Yes, packs per day: _____

Alcohol:

☐ Never ☐ Former ☐ Yes, drinks per week: _____

Type: _____

Illicit Drugs:

☐ Never ☐ Former ☐ Yes, type:_____

Caffeine:

☐ Yes ☐ No

Type: ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink ☐ Chocolate

Daily Intake: _____

Lifestyle:

Are you on a specific diet? ☐ No ☐ Yes, type: _____

Do you exercise regularly? ☐ No ☐ Yes, type:_____

How many days per week? _____ How long per day? _____

Drug Allergies: ☐ No ☐ Yes, LIST:

_____

_____

_____

Other symptoms or problems: Check any that apply or ☐ NONE

☐ Weight Loss	☐ Hair Growth	☐ Change in Energy
☐ Weight Gain	☐ Hair Loss	☐ Change in Exercise Tolerance
☐ Breast Discharge	☐ Hot Flashes	☐ Change in Urinary Function
☐ High Cholesterol	☐ Physical Abuse	

☐ Other (specify) _____

Family History: Check any that apply or ☐ NONE

	YES	DECEASED (Note age & cause)	AFFECTED RELATIVES (Parents, Siblings, Offspring)
Diabetes	☐	_____	
Ovarian Cancer	☐	_____	
Heart Disease	☐	_____	
Endometrial Cancer	☐	_____	

Breast Cancer ☐ _____

Colon Cancer ☐ _____

Other/Specify ☐ _____

Authorization for Care:

I certify that the information on my intake form is correct to the best of my knowledge. I will not hold Dr. Miki or any staff member of Ashland Natural Medicine responsible for any errors or omissions that I may have made in the completion of this form. I hereby authorize this office to provide me with Gynecological care, Holistic™ Pelvic Therapy and/or acupuncture in accordance with this state's statutes.

Patient or Guardian signature_____

Date_____

*__Policy Reminders__: Refills for prescriptions and custom tinctures require 72 hours' notice. Refills can be picked up during our normal clinic hours: Monday and Thursday, 10:00 AM – 5:00 PM or on Tuesday, Wednesday, and Friday, 9:00 AM - 5:30 PM. We are closed 12:30 – 1:30 PM for lunch.

Please remember, we require 72 hour cancellation notice, as charges will apply. Thank you.