BRADEN RICHMOND, M.D., F.A.C.O.G.

'Special Care For Women'

OBESTETRICS, GYNECOLOGY, AND INFERTILITY

Date:_____ Date of Birth:_____ Age: _____

Name_____
First Middle Last

Nature of problem or reason you are being seen(include a brief description):_____

_____

_____

_____

_____

_____

Date of last: Pap smear month/year _____ Where _____

Mammogram month/year _____ Where _____

Have you ever had an abnormal pap smear?_____ Date _____ Final Result_____

Have you ever had an abnormal Mammogram?_____ Date _____ Final Result_____

Birth Control Method: (please circle) **None Not Applicable Abstinence Natural Planning**
Nexplanon Tubal Ligation Vasectomy Hysterectomy
Condoms Diaphragm Pill Patch Ring Depo IUD
Other method: _____

Date of Last Period:_____

History of Pregnancies: Full Term Births _____
Premature Births _____
Miscarriages _____
Abortions _____
Number of living children _____

Please list the Pharmacy & the location that you use_____
(This is where your medications will be sent)

Previous Surgery and Year (Include C-Sections):
_____
_____
_____
_____
_____

Family Doctor: _____

Previous Illnesses/Hospitalizations and Dates:
_____
_____
_____

List Drugs you are allergic to (describe type of reaction)
_____
_____
_____

Current medications (Include strength and schedule)
_____
_____
_____
_____
_____

Do you smoke? Yes No
If yes, age at onset _____
# of cigarettes a day _____

Drink alcoholic beverages? Yes No
If yes, circle: rarely socially most days
Do you use illegal drugs? Yes No

Have you ever had a serious illness with you (if yes please describe):

Brain Y N _____ **Liver Y N**
Vision Y N _____ **Stomach Y N**
Hearing Y N _____ **Intestines Y N**
Heart Y N _____ **Kidneys Y N**
Lungs Y N _____ **Bladder Y N**

Do you have a history of: (Y or N)

____ Arthritis
____ Asthma
____ Bleeding Disorder
____ Clotting Disorder
____ Blood Transfusion
____ Clot in the leg (DVT)
____ Diabetes
____ High Blood Pressure
____ Lupus
____ Mental Disorder
____ Seizures
____ Skin Disease
____ Thyroid Dysfunction
____ Other _____
____ Other _____

Family History

	Age if Living	Age at Death	If Deceased: Cause of Death	Has Any Blood Relatives Ever Had	Please Circle	Which Relatives
Father:				**Breast Cancer**	**Yes No**	
Mother:				**Diabetes**	**Yes No**	
Brother/Sister:				**Osteoporosis**	**Yes No**	
				Cancer	**Yes No**	
				High Blood Pressure	**Yes No**	
				Heart Disease	**Yes No**	
				Kidney Disease	**Yes No**	
Husband:				**Liver Disease**	**Yes No**	
Children:				**Alcoholism**	**Yes No**	
				Drug Addiction	**Yes No**	
				Mental Disease	**Yes No**	
				High Cholesterol	**Yes No**	
				Anesthesia Problem	**Yes No**	

How old were you when your periods started? _____

How many days between the beginning of each period (such as 28 days)? _____

Are periods monthly? Y N

How many days does your period last? _____

Is your flow (circle): Light Medium Heavy Extreme

How is your pain with your periods (circle)? Minimal Mild Moderate Severe

Signature: _____ Date:_____

THANK YOU! Your complete answers on this form will help us better evaluate your total health.