Wafika M. Fahmy, M.D.
2303 17th Street
Bakersfield, CA 93301

Date of Visit:_____

Name: _____

LAST FIRST MIDDLE

Date of Birth: _____

For what reason are you coming?

Past Medical History:

Please check any medical problems with which you have EVER been diagnosed:

- High blood pressure_____
- Diabetes_____
- Heart Problems_____
  -Angina or Coronary artery disease_____
  -Heart attack_____
  -Congestive heart failure_____
  -Irregular heart beats_____
- Liver Problems_____
  Hepatitis: A _____ B_____ C_____
  Gall Bladder Attacks_____
- Neurological Problems_____
  Stroke_____ Seizure_____
- Stomach Problems_____
  Ulcer_____ Acid Reflux_____
- Bleeding Disorders_____
- Blood Clots_____
- Lung Problems_____
  Asthma_____ Tuberculosis_____ Emphysema_____
- Kidney and Bladder Problems_____
- Thyroid Problems_____
  Hypothyroidism_____ Hyperthyroidism_____

- Serious Infection_____
- Cancer_____
  Type_____
  Radiation_____
  Chemotherapy_____
- Have you ever been hospitalized?_____

Past Surgical History:

Please list all of the surgeries you have had and the dates.

Type of Operation	Date
_____	_____
_____	_____
_____	_____
_____	_____

Obstetric and Gynecologic History:

What is the first day of your last period?_____
At what age did you start your period?_____
What are the numbers of days you bleed?_____
What are the numbers of days between periods?_____
What is the amount of bleeding?_____
Do you bleed between periods?_____
Do you have pain with the period?_____
Before_____
During_____
After_____
Do you have pain between the periods?_____
Do you have pain with intercourse?_____
Do you have any abnormal vaginal discharge?_____If yes,
Color?_____, Any itching or burning?_____
Since when?_____
How many times have you been pregnant?_____
How many full term births?_____How many pre-term deliveries?_____
How many miscarriage or abortions?_____
Have you ever used any method to prevent pregnancy?_____If yes,

What type_____ For how long?_____
What type_____ For how long?_____
What type_____ For how long?_____
Are you currently using birth control method?_____ What?_____
Since when?_____
Have you ever taken hormone replacement therapy?_____ What?_____
Since when?_____
Have you had any gynecologic problems in the past?_____
Abnormal Pap Smears_____ Ovarian cysts_____
Endometriosis_____ Infertility_____
Sexually transmitted diseases_____ What?_____
Heavy bleeding requiring medication or surgery?_____
Pelvic prolapse or urinary problems?_____

Allergy:

Any allergies to medication?_____ Which drugs?_____
What type of reaction?_____
Do you have any other allergies?_____

Medications:

List all Medications you take including the dose and frequency:
1)_____
2)_____
3)_____
4)_____
5)_____

Family History:

Please list all medical or surgical problems in the family:

_____
_____
_____

Social History:

Single_____ Married_____ How Long?_____ Divorced_____ Widowed_____
What type of work do you do?_____
Do you smoke?_____ Did you use to smoke?_____ How many packs per day?_____
How long?_____
Do you drink alcohol?_____ If yes,
How much do you consume typically per week?_____ How long?_____
Do you use any type of recreational drugs?_____ Last use?_____