Michael Ivchenko, M.D. | Obstetrics . Gynecology . Infertility | Carrie Schallock, M.D
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WELCOME TO OUR OFFICE

THANK YOU FOR CHOOSING OUR OFFICE.
IN ORDER TO SERVE YOU PROPERLY WE WILL NEED THE FOLLOWING INFORMATION.
ALL INFORMATION WILL BE STRICTLY CONFIDENTIAL.

PATIENT NAME ____ **DATE** ________________

CHIEF COMPLAINT

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MENSTRUAL HISTORY		
Age at Onset:	Cramps:	Last Pap:
Cycle Length:	Last Period:	Result:
Length of Period:	Age at Menopause:	Contraception:
Flow: Lt./Med/Hvy	Hot Flashes:	

PREGNANCY HISTORY

Term Pregnancies:_______ Premature: _______ Miscarriages: _______ Abortion: _______ Living Children: _______

	1	2	3	4	5	6
Year						
Duration of Pregnancy						
Length of Labor						
Type of Delivery						
Birthweight & Sex						
Complications						

PAST GYNECOLOGICAL HISTORY

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PAST MEDICAL HISTORY

	Patient	Family		Patient	Family		Patient	Family
Hypertension			Anemia blood disorders			Birth Defects		
Headaches			Blood Transfusion			Smoking (Cig/Day)		
Respiratory			Blood Clots/Phlebitis			Alcohol (Oz./Wk)		
Breast Disorder			Diabetes			Drugs		
Jaundice/Hepatitis			Thyroid Disease			Gardasil		
Gall Bladder Disease			Cancer			Abuse/Safety Concerns		
Bowel Problems			Epilepsy/Neurological			Sexual Concerns		
Kidney Problems			Heart Disease			Other		
Bladder Problems			Ulcers					

HOSPITALIZATIONS/SURGERIES

Month/Year	Illness	Month/Year	Illness

MEDICATIONS	ALLERGIES

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO PROCESS MY INSURANCE CLAIM

____ ________________________
Patient Signature Date