West Coast Ob/Gyn, Inc.

☐ 7695 Cardinal Court
Suite 240
San Diego, CA 92123

☐ 8860 Center Drive
Suite 360
La Mesa, CA 91942

☐ 6125 Paseo Del Norte
Suite 200
Carlsbad, CA 92011

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Preferred Language: _____

Name of PCP: _____ How did you find WCOB?: _____

Reason for today's visit: _____ Annual Exam: Y / N

Preferred pronouns (please circle): She/her He/Him They/Their

CURRENT MEDICATIONS/SUPPLEMENTS: Please list all prescription and over the counter medications.

Name	Dose	Name	Dose

ALLERGIES:

Allergen	Reaction	Allergen	Reaction

MEDICAL PROBLEMS (past and current): Please check all that apply.

☐ Diabetes (type I or II):	☐ Thyroid disease
☐ High blood pressure	☐ Blood clots in legs or lungs
☐ Asthma	☐ Migraines
☐ COPD	☐ Depression
☐ Sleep apnea	☐ Anxiety
☐ Cancer (please describe):	☐ Other mental health diagnosis
List any additional:	

PREVIOUS SURGERIES (including cosmetic):

Year	Surgery

OBSTETRICAL HISTORY: Please list pregnancies in order including miscarriages, ectopics, and abortions.

Year	# of Weeks (preterm?)	Birth Weight	Type of Delivery (Vaginal or C-section)	Sex (M/F)	Epidural (Y/N)	Complications

GYNECOLOGIC HISTORY:

Date of last Pap Smear: _____
Result of last Pap Smear: _____
Date of last Mammogram: _____
Results of last Mammogram: _____

History of abnormal Pap Smear: Y / N
If yes, when? _____

Periods: Monthly / Irregular / None
First day of last menses: _____
How many days do you bleed? _____
Age at menopause (if applicable): _____

Do you bleed between menses? Y / N
Are they heavy or painful? Y / N
History of hormone replacement? Y / N

Method of birth control (please circle):
Pills IUD Implant Ring Condoms Tubal Ligation Vasectomy ☐ Trying for pregnancy

History of sexually transmitted infections (please circle all that apply):
HPV Herpes Chlamydia Gonorrhea HIV Hepatitis C Syphilis Trichomonas Other:

SOCIAL HISTORY:

Status: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Sexually active: Y / N with: ☐ Men ☐ Women ☐ Both Concerns:
Occupation:
Hobbies:
Religious/Cultural affiliations:
Exercise (type and frequency):
Alcohol use? ☐ None ☐ Monthly or less ☐ 2-3x/month ☐ 2-3x/week ☐ >4x/week
Tobacco use (include vape)? Y / N
Recreational drug use (past or present)? Type? Y / N
History of abuse (sexual, emotional, or physical): Y / N

FAMILY HISTORY: Please mark all that apply or check here if adopted/unknown ☐

Disease/Condition	Family member and age at diagnosis
Cancer: ☐ Breast ☐ Ovarian ☐ Uterine ☐ Colon	
Other Cancer:	
☐ Diabetes	
☐ High blood pressure	
☐ Heart disease/heart attack	
☐ Stroke	
☐ Bleeding or clotting disorders	