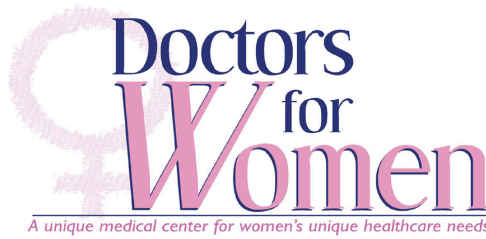


**GYNECOLOGIC SURVEY**

(CIRCLE DOCTOR)

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TODAY'S DATE \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_

REFERRED BY \_\_\_\_\_

PREGNANT ? YES \_\_\_\_\_ NO \_\_\_\_\_

REASON FOR APPOINTMENT \_\_\_\_\_

\_\_\_\_\_

NUMBER OF PAST PREGNANCIES \_\_\_\_\_

BORN ALIVE \_\_\_\_\_ STILL BORN \_\_\_\_\_

WEIGHT OF LARGEST \_\_\_\_\_ SMALLEST \_\_\_\_\_

AGE OF OLDEST \_\_\_\_\_ YOUNGEST \_\_\_\_\_

MISCARRIAGES \_\_\_\_\_ PREGNANCY TERMINATIONS \_\_\_\_\_

**HISTORY OF LABOR AND DELIVERY:**

COMPLICATIONS \_\_\_\_\_

BIRTH DEFECTS \_\_\_\_\_

LONGEST LABOR \_\_\_\_\_ HRS    SHORTEST LABOR \_\_\_\_\_ HRS

C-SECTIONS    YES \_\_\_\_\_    NO \_\_\_\_\_

**PAST MEDICAL HISTORY**

ANY SERIOUS ILLNESSES \_\_\_\_\_

\_\_\_\_\_

PREVIOUS SURGERIES \_\_\_\_\_

\_\_\_\_\_

CURRENT MEDICATIONS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ALLERGIC TO MEDICATIONS \_\_\_\_\_

\_\_\_\_\_

DO YOU SMOKE?    YES \_\_\_\_\_    NO \_\_\_\_\_

LAST PAP TEST \_\_\_\_\_ NORMAL \_\_\_\_\_ ABNORMAL \_\_\_\_\_

**MENSTRUAL HISTORY**

PERIODS OCCUR EVERY \_\_\_\_\_ DAYS

PERIODS LAST \_\_\_\_\_ DAYS

CRAMPS?    YES \_\_\_\_\_    NO \_\_\_\_\_

MILD \_\_\_\_\_ MODERATE \_\_\_\_\_ SEVERE \_\_\_\_\_

LAST PERIOD BEGAN \_\_\_\_\_

ENDED \_\_\_\_\_

**FAMILY / PERSONAL HISTORY**

	YES	NO
THROMBUS / BLOOD CLOT	_____	_____
DIABETES	_____	_____
HIGH BLOOD PRESSURE	_____	_____
FEMALE CANCER	_____	_____
BREAST	_____	_____
OVARY	_____	_____
UTERUS	_____	_____
CERVIX	_____	_____

**BIRTH CONTROL**

NAME OF BIRTH CONTROL PILLS \_\_\_\_\_

CONDOMS \_\_\_\_\_ IMPLANT \_\_\_\_\_

PATCH \_\_\_\_\_ NUVARING \_\_\_\_\_

OTHER \_\_\_\_\_

TUBAL LIGATION ?    YES \_\_\_\_\_    NO \_\_\_\_\_

**MAMMOGRAMS**

LAST MAMMOGRAM \_\_\_\_\_

NORMAL \_\_\_\_\_ ABNORMAL \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

PRIMARY DOCTOR \_\_\_\_\_

YOU MAY FAX FORM BACK TO 318-797-0010

OR EMAIL BACK TO: OBGYNCLINIC@ME.COM