THERMIva

Heron Med Spa

Obstetrics and Gynecology History Form

Name: ____

Address: ____

City: ______________________________ State: _______ Zip Code: ____________

Home Phone Number: ___________________ Cell Phone Number: __________________

Employer: ______________________________ Work Phone Number: _________________

Date of Birth (M/D/Y): ______________________ Age: ________ Gender: F_____ M_____

Height: ______ Weight: ______ lbs **(completed by staff during visit)**

Race: ____Black or African American ____ White ____Hispanic/Latino _____Other

Language: _____English _____Spanish ______Other: _________________________

Emergency contact: _____________________________________ Phone _______________

Do we have your permission to:

Leave a message on your answering machine at home? YES NO

Leave a message at your place of employment? YES NO

Discuss your medical condition with any member of your household? YES NO

If yes, whom:___________________________________ Relationship______________________

Primary Care Physician: ____________________________ Phone __________________________

Ob-Gyn: _____________________________________ Phone __________________________

Reason for Visit

Please be as specific as possible ____

How long have you had this condition? ____

Have you had any previous treatment for this condition? ______________________________

If YES, how and when was this treated? ____

____

Name: ____

Past Medical History: Please list all prior medical diagnosis

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Past Surgical History: Please list all surgeries and dates

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Please List Significant Medical Conditions in your Family, and who has/had them (breast cancer – mother, heart disease – grandfather, etc):

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Medication Name	Dosage	Frequency

If necessary, continue on back.

Date of Last Menstrual Cycle:__________________ # of Days Between Cycles: __________

# of Days Menstrual Period Lasts______ Are your periods: Regular: _____ Irregular:______

Flow: Light Moderate Heavy Cramps: Mild Moderate Severe
(mark with an "**X**")

Are you having any menstrual problems? If yes, please describe ____________________________
____

If you are menopausal, do you have vaginal bleeding? ____________________________________

When was your last PAP test?: _____________ Date of last mammogram: ______________

Current Contraception: ____

Are you currently sexually active? ______Yes ________No

Do you want to be tested for sexually transmitted diseases (STD)? _________________________

Please circle: Have you ever had any of the following STDs:

None Chlamydia Gonorrhea Venereal Warts Genital Herpes HPV Other_________

Name: ____

Review of Systems:
Please **X** any of the following that you are currently experiencing problems with:

Unexplained weight change
Fever
Dizzy spells/fainting
Chest pain
Irregular heartbeat/Palpitations
Coughing
Trouble breathing
Nausea
Vomiting
Constipation
Diarrhea
Blood in Stools

Unusual fatigue
Heartburn/Indigestion
Trouble with balance
Severe joint/muscle pain
Skin lesions
Headaches
Trouble sleeping
Hot flashes/Night Sweats
Pelvic pain
Breast pain
Excess body/facial hair
Premenstrual symptoms

Heat or cold intolerance
Decreased sexual desire
Frequent bruising
Pain or bleeding with sex
Pain during urination
Increase in urinary frequency
Blood in urine
Urinary Incontinence
Vaginal discharge/odor
Vulvar itching or rash
Vaginal dryness
Victim of sexual abuse

______________________________________ ____________
Signature Date

Marketing Authorization and Use of Photographs

According to federal law **we must ask for your permission to send to you via email, text, social media or regular mail** information regarding our practice such as products we sell, promotions we have or any services the practice offers (i.e., office promotions that include special discounts, Open House invitations).

Our office DOES NOT SELL or SHARE our patient's names.

This authorization is effective until revoked in writing.

I voluntarily sign this authorization, and **I understand that my health care will not be affected if I do not sign this form.** I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying Heron Med Spa in writing or email. I understand that my revocation or modification of this authorization will not affect any actions taken by Heron Med Spa in reliance on this authorization before Heron Med Spa receives my request for revocation or modification. I must sign my written request and send it to:

Privacy Contact
Heron Med Spa, 321 South Patrick Street, Alexandria, VA 22314

I **DO** __________ I **DO NOT** _____________ **Please select one**

Authorize Heron Med Spa services or promotions the practice offers. You may choose email, cell phone or both.

I **DO** __________ I **DO NOT** _____________ **Please select one**

Authorize Heron Med Spa to use my photographs.

____ ____________________

Patient Signature Date

____

Email Address Please Print

____

Cell Phone Number