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Specializing in Gynecology, Urogynecology, and Well Woman Care

Name:_____ **Name you would like to be called**?_____

Referred by:_____ **Primary Care Doctor:**_____

Reason for your visit today:

- ☐ Abnormal Radiologic Finding
- ☐ Abnormal Pap Smear
- ☐ Annual Well Woman Exam
- ☐ Bleeding Problems
- ☐ Breast Symptoms
- ☐ Contraception Issues
- ☐ Menopause/Perimenopause Issues
- ☐ Menstrual Symptoms
- ☐ Pain: Abdominal/Pelvic
- ☐ Prolapse
- ☐ Urinary Incontinence or Symptoms
- ☐ Vaginal/Vulvar Symptoms

☐ Other/Please explain:_____

Gynecologic History:

Last menstrual period - date :_____
Age of first period_____ Age of menopause: _____
Period Every _____days. Lasts _____ days.
☐ Heavy periods? ☐ Cramps? ☐ PMS/moodiness?
Sexually active? ☐ Yes ☐ No ☐ Not currently ☐ Never
Intercourse a problem? ☐ No ☐ Yes_____
Sexually Transmitted Diseases? ☐ No ☐ Yes _____
Current Birth control method:_____
Hysterectomy:☐ Complete ☐ Partial Year____ Age_____
☐ Hot Flashes? ☐ Night sweats? ☐ Decreased libido?
Other symptoms/problems:_____

Obstetrical History:

Total pregnancies: _____
Full-term deliveries: _____
Preterm deliveries: _____ Weeks:_____
Miscarriages: _____
Abortions: _____
Ectopic/Tubal pregnancies: _____
Twin pregnancies: _____
Living children: _____
Largest: _____lbs _____oz
C-sections: _____
Complications: _____ ☐ None

Last Pap smear? _____ Date of Abnormal Pap _____ Treatment for abnormal Pap? ☐ No Yes_____
Last mammogram? _____ Do you do regular Breast Self Exam? ☐ Yes ☐ No ☐ Occasionally.
DEXA bone density scan? ☐ No ☐ Yes - Year _____ ☐ Osteoporosis ☐ Osteopenia
Screening Colonoscopy? ☐ No ☐ Yes - Year _____ ☐ Normal ☐ Polyps ☐ Diverticulosis

Past Medical History:

- ☐ High Blood Pressure
- ☐ Heart Disease/Stents/Heart Valve
- ☐ Heart Attack/MI
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Stroke/TIA
- ☐ GERD, Reflux
- ☐ Thyroid disease
- ☐ High Cholesterol
- ☐ Diverticulosis/Diverticulitis
- ☐ Asthma or Chronic Bronchitis
- ☐ Kidney stones
- ☐ Depression
- ☐ Anxiety/Panic attacks
- ☐ Breast Cancer
- ☐ Headaches
- ☐ Cataracts or Macular Degeneration
- ☐ Glaucoma
- ☐ Blood clotting disorder/DVT/PE
- ☐ Osteoporosis/Osteopenia
- ☐ Other_____

Surgical History: Please list all surgeries and biopsies that you have undergone

Procedure	Date (year)	Procedure	Date (year)
Have you ever had any problems with anesthesia? ☐ Yes ☐ No Had a Blood transfusion? ☐ Yes ☐ No			

******PLEASE COMPLETE BOTH SIDES OF THIS FORM******

Name:_____

Medications: including vitamins ,herbal and over the counter medications: **Allergies** to Medications

Medication and Dose	**Medication and Dose**	**Allergies**
1.	6.	
2.	7.	
3.	8.	
4.	9.	
5.	10.	☐ **No Known Drug Allergies**
Pharmacy name and location:		**Pharmacy # ( ) -**

Are there any supplies that you get from a Home Health Company? (e.g. Glucose strips, cane walker, toilet..etc)

Family History:

☐ Unknown Family History	What family relation	Age of death
☐ High blood pressure		
☐ Diabetes		
☐ Heart Attack/Heart Problems		
☐ Stroke		
☐ Breast, Ovarian, Uterine, Cervical Cancer (**circle**)		
☐ Other Cancer -Type_____		
☐ Colon Cancer		
☐ Depression/Anxiety		
☐ Thyroid disease		
☐ Elevated Cholesterol		
☐ Osteoporosis		
☐ BLOOD CLOTTING DISORDER		
OTHER: _____		

Social History:

Are you: ☐ single ☐ engaged ☐ married ☐ separated ☐ widowed ☐ divorced ☐ living with partner?
What is your diet like?_____ Calcium per day? ☐ 1000 mg ☐ 500 mg ☐ None ☐ Don't know
What is your occupation? _____Do you exercise regularly? ☐ Yes ☐ No.
Do you: ☐ smoke cigarettes? _____ pack/s per day ☐ never smoked ☐ quit smoking _____(Year).
Do you drink alcohol ? ☐ Never ☐ Rare ☐ Occasional _____drinks/wk Use any illicit drugs? ☐ Yes ☐ No.
Wear seat belts? ☐ Yes ☐ No Smoke detector? ☐ Yes ☐ No. Immunizations up to date? ☐ Yes ☐ No.
Have you ever been abused? ☐ No ☐ Yes ☐ physically ☐ sexually ☐ emotionally abused? Safe now? ☐ No ☐ Yes.

Review of Systems: Please circle any other symptoms that you may be having:

☐ General: Weight gain, Weight loss, Fatigue, Loss of height
☐ Eyes: Vision changes, Blurring, Corrective lenses
☐ Ears, Nose, Mouth, Throat: Drainage, Discharge, Hoarseness, Hearing problems, Vertigo
☐ Cardiovascular: Chest Pain, Leg pain with walking, Shortness of breath with exertion, Leg swelling
☐ Respiratory: Wheezing, Cough, Sputum production
☐ Gastrointestinal: Nausea, Vomiting, Blood in stools, Change in stools, Diarrhea, Constipation, Pain with BM
☐ Musculoskeletal: Back pain, Arthritis, Weakness
☐ Skin and/or Breast): Rash, Change in moles, Nipple discharge, Breast lumps, Breast Pain
☐ Neurologic: Numbness, Dizziness, Headaches Difficulty walking, Fainting spells, Tremors
☐ Psych: Anxiety, Depression, Difficulty sleeping,
☐ Endocrine: Hot/cold intolerance, Excessive thirst
☐ Hematologic/Lymphatic: Easy bruising, Swollen glands, Anemia, Blood clotting disorder
☐ Allergy: Seasonal allergies, Healing, Problems, Steroid use, Iodine allergy, Latex allergy

OTHER Symptoms:_____
_____

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